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Reproducing the State:
Women Community Health Volunteers in North India

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Abstract

Reproducing the State:
Women Community Health Volunteers in North India

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India's community health worker program is the largest in the world. Its one-million strong, all-women workforce is a success story. Since their appointment in 2005, these women, called ASHAs (Accredited Social Health Activists), have spearheaded significant improvements in the country's maternal and child health outcomes. However, ASHAs are an exceptionally precarious workforce. They are "paid volunteers", who receive none of the benefits of staff, and get per-case "incentives" instead of salaries. These poor and mostly lower caste women work round-the-clock in an under-resourced and over-burdened health system, for an itinerant pay that is a fraction of minimum wage. Given these conditions, I ask, how do ASHAs succeed in delivering health services? And what does their success tell us about state power? I conducted 14 months of ethnographic fieldwork in North India, mostly in Punjab, including 80 interviews with ASHAs and ASHA program experts. I find that ASHAs reveal the productive power of an under-studied and gendered role in the state, that of a frontline bureaucrat. Frontline bureaucrats expand the reach of the state into communities. Although the gender, caste, and class marginality of ASHAs subsidizes the Indian state's health system, ASHAs craft themselves into highly

sought-after actors in service delivery. They do so by cultivating deeply intimate knowledge of women clients and their families, and by building networks among both public and private health care providers. In this way, they get not just intrinsic rewards—like skills, emotional fulfilment etc. usually associated with care work—but also extrinsic rewards, like commissions earned by referring patients to private clinics. I also find the care work of ASHAs comprises political socialization, that is, ASHAs educate their communities about the workings of the state, particularly welfare schemes, thus maintaining state legitimacy from below. In effect then, the very marginality that traps ASHAs into care work also unexpectedly allows them to maneuver into a social location of relative power within their communities.

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Introduction

THE PUZZLE

From 2009 to 2015, before I joined the PhD program in Sociology at the University of Texas at Austin, I worked with feminist nonprofits in Delhi. Much of this work was centered on reproductive health issues. During this time, I was part of many meetings and conferences that saw participation from activists, academics, development professionals, and government officials working at the intersection of gender and health. It was at these meetings that I first learned about ASHAs, or Accredited Social Health Activists, India's one million strong, all-women workforce of community health volunteers.

Long before I had ever met an ASHA, it was clear to me ASHAs were a very important workforce. It seemed like whatever the public health issue under discussion, ASHAs would come up as part of the solution, or the problem. For instance, in a presentation on how to reduce the stigma around mental health in Goa, it was suggested that ASHAs be enlisted to spread awareness among communities. In another presentation on the rights of tuberculosis patients, the presenter drew attention to how ASHAs were key to administering DOTS (Directly Observed Treatment Short) on schedule. These discussions usually included customary nods to the ASHAs' point of view. Someone would bemoan, to sympathetic clucks from the room, how overworked ASHAs are, how underpaid, and how poorly equipped, to manage their many responsibilities. This was the beginning of my interest in ASHAs.

On the face of it, the ASHA program is a success. ASHAs were first appointed in 2005 as a rural workforce, restricted to Indian states with the poorest reproductive health outcomes (Scott et al 2019). However, soon other states saw value in the program. ASHAs began to also be

appointed to marginalized urban settlements. Today, the ASHA program is a nationwide one. Since its implementation in 2005, the National Health Mission (NHM)—under which ASHAs were appointed—has led to significant improvements in India's maternal and child health outcomes. As foot soldiers of the NHM, ASHAs have spearheaded these changes.

Take maternal mortality for example. With a staggering 45,000 maternal deaths a year, India is home to 17% of the global maternal mortality burden (Rao 2017). With NHM, the Indian government began to aggressively promote hospital births to reduce this burden. ASHAs were tasked with connecting women from their communities to the government health services. Their primary responsibility was to track pregnant women, provide them with check-ups and medication, and when they are due, ensure they deliver in a hospital instead of at home (for which mothers receive a cash transfer). This approach is considered fairly successful; at least before Covid-19 related disruptions hit in 2020, the Indian government was lauded by international bodies for reducing maternal and child mortality rates, and for improving vaccination coverage and institutional delivery (hospital births) (Singh 2018). Fittingly then, the acronym ASHA is also the word for 'hope' in Hindi.

Upon closer examination, though, it is not clear what drives this 'hope'. In other words, why do ASHAs succeed at their work? India, after all, spends notoriously little on public health—less than 1.5% of its GDP (Pai 2017), resulting in major infrastructural and personnel gaps in the public health system. Within this paucity-ridden system, ASHAs occupy the lowest rung. ASHAs are the only health department workers who are not even recognized as workers. They are, technically, volunteers. They must be available round-the-clock, but they do not receive salaries. Instead, they are paid case-based incentives that amount to average monthly earnings equivalent to a fraction of minimum wage. As the only health department workers who live among their

patients and regularly go door-to-door in their communities, ASHAs form a critical link between marginalized communities and the public health system. As such, their burden of work has expanded over the years, much beyond their initial focus on reproductive health, to include tuberculosis, malaria etc. and now Covid-19.

The empirical puzzle for me, then, is why women persist, indeed succeed, as ASHAs. In the summer of 2017, while doing preliminary fieldwork in Punjab, I had an early clue. This is a fieldnote from the first time I met ASHAs:

> We are just outside Punjab's capital. Rupinder Kaur is one of ten ASHAs who has stayed back to speak with me after a leprosy training at the local health center. Rupinder is tall and expressionless. But hers is the most passionate in a chorus of voices complaining about how hard their work is. Rupinder has just spent three days going door to door in her village of 1000 residents, ensuring every child is vaccinated against polio. This is strenuous work in the north Indian summer, when temperatures routinely cross 110 degrees Fahrenheit. Her family has been taunting her, telling her she prefers the company of outsiders to being with them at home. Her voice gets louder: "For three days of running around, I got Rs. 135 (USD 2)! Can you believe it? I can make much more as a day laborer!" She pauses. I also pause my notetaking to look up at her, just as she cracks a wry smile. She adds: "But look, we were *aam* (insignificant). And now, we have become madam!"

In essence, my research investigates the madam-ness Rupinder spoke of that day. By what alchemy do women turn a role so bleak and burdensome as to seem impossible, into one so special they are loath to leave it? How do ASHAs—who in my field site were mostly poor, Dalit women with low levels of education—maneuver their marginality into positions of relative status and privilege in their communities? At what point does exploitation become opportunity? To put it in terms of research questions: Given the odds against them, why do ASHAs continue working? How do ASHAs succeed in delivering maternal and child health services? As I will show, the answers to these questions illuminate the micro-workings of power in the state, specifically the kind of agency that exists at the intersection of statist power and gendered disempowerment. After all, ASHAs are what Lipsky (1980) calls "street-level bureaucrats," that is, public employees who

interact directly with citizens in the course of their jobs. In these interactions, the ASHAs do much more than promote health services, and they gain much more than patients for the state.

In the next section, I situate my research within the literature. I begin with my main focus, the literature on bureaucracy and bureaucratic encounters as a strategic site for the examination of state power. Because ASHAs are street-level bureaucrats who perform a particular kind of role—paid care work—I also explore the sociological literature on care and paid care workers, before narrowing my focus further to community health workers, who are a subset of care workers.

LITERATURE REVIEW

Bureaucracy and state power

The study of bureaucracy has much analytical and practical merit. Bureaucracy has been identified by both Weber (1958) and Foucault (1978, 1991) as *the* ubiquitous and distinct domination of the modern age. For Weber, the "iron cage" of bureaucracy is both coercive and enabling, but inherently de-personalizing. All its features—its functional specialization, methodical integration of functions, expert training, tenure and material security, social esteem, to name a few—are oriented towards the discharge of business with calculable rules and without regard for individuals. As such, bureaucracy's rationalized nature is a key characteristic of the modern state. As Weber explains, the material fate of the masses comes to depend on the correct and continuous functioning of bureaucracy. Structurally, this ensures not only its own continuation, but also the suppression of new forms of political power.

For Foucault, the emergence of population (rather than territory and fealty) as the right object of government is concomitant with the disciplining and management of populations—of power

over life—through governmentality[1]. In Foucauldian analysis, power is productive and capillary, rather than repressive and singular. In Foucauldian terms then, bureaucratic practice is a modality through which individuation and structuration (the coordination of individuals) is achieved, and through which government-at-distance enables a proliferation of sites of domination. A certain complementarity can be read into Weber and Foucault on the question of bureaucracy: the former is interested in rationalization, while the latter in rationalities of practices and embodied strategies (Power 2011).

Contemporary studies of bureaucracy tackle the issue of bureaucratic indifference, and its relationship with violence, in both structural and cultural terms. In *Modernity and the Holocaust* (Bauman 1992), sociologist Zygmunt Bauman identifies the silencing of morality as a condition for the success of bureaucracy. This makes holocaust a permanent possibility under modernity. For this possibility to be realized, bureaucracy's meticulous functional division of labor that creates social distance between actor and action, and organizational discipline that recasts moral responsibility as technical responsibility, must both come together with a modern-day racism that evicts its victims from a universe of national obligation. For Bauman, bureaucracy is like loaded dice; it has a perverse logic and momentum of its own that renders some solutions more probable than others. Anthropologist Michael Herzfeld (1992) brings cultural analysis to this thesis on bureaucratic indifference. Using ethnographic evidence from Southern Europe and the Mediterranean, he argues that although the state claims rationality as its basis, non-rational symbolism (i.e., kin idioms of language and blood) is not surpassed but coopted and re-presented by the state as classification systems. This is what enables those who fit these systems to be treated as insiders to the nation, and those who do not to be treated, *a la* Mary Douglas, as dirt. Herzfeld

[1] Governmentality refers to an ensemble of practices, apparatuses, expertise, institutions, calculations—in other words, technologies of self and techniques of rule—that create the effect of the state.

agrees with Weber that bureaucracy is a secular theodicy—people regard their experience with bureaucracy as one step removed from divine providence, wherein outcomes are a matter of luck and fate—but he disagrees with Weber that bureaucracies generate accountability; instead, he argues that they mystify it. Akhil Gupta picks up where Herzfeld leaves off. In *Red Tape* (2012), Akhil Gupta argues that the death of millions from poverty in India, despite the existence of anti-poverty programs, is a form of direct, culpable killing made possible by bureaucratic procedures. Bureaucracy repeatedly and systematically produces arbitrary outcomes in the provision of care. Therefore, bureaucracy generates not just indifference as Herzfeld shows, but indifference to the *arbitrariness* of outcomes. Rather than Weberian ideals of replicability and consistency, bureaucracy is characterized by contingency and barely controlled chaos, such that uncaring becomes the constitutive modality of the state even at sites of care like welfare camps.

Notably, while Bauman regards distance as fundamental to bureaucratic indifference, Herzfeld and Gupta examine indifference in more proximate settings. The study of proximate bureaucratic encounters, in a field traditionally regarded as characterized by distance, has been hugely generative. This is particularly true of studies of welfare services for the poor.

Michael Lipsky's classic text *Street-level bureaucracy: Dilemmas of the individual in public services* (Lipsky 1983) discusses "the schools, police and welfare departments, lower courts, legal services offices, and other agencies whose workers interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions" (1983: 11). Street-level bureaucrats are public employees who interact directly with citizens in the course of their jobs. They are usually frontline workers who create a localized experience of the state for the poor who rely on their services. Their work is characterized by relative autonomy from organizational authority, and a high degree of discretion. Because the conditions of their work—such as a chronic shortage of

resources, vague or conflicting agency goals, difficulties in performance measurement, and the provision of service to involuntary clients—usually make it impossible to achieve the expectations of their work, street-level bureaucrats often behave in ways that are unsanctioned by, and sometimes even contradictory to, official policy.

Lipsky argues that the individual solutions street-level bureaucrats devise to work pressures add up to create public policy. Through the decisions they make, the routines they establish, and the devices through which they cope, these workers do much more than implement policy; they effectively make it. As such, their role is a political one. Here Lipsky seeks to move away from a top-down understanding of public policy, one that regards policy as made by legislators and top administrators, to emphasize instead the "important ways it is actually made in the crowded offices and daily encounters of street-level workers" (1983: 12).

However, given that street-level bureaucrats regulate access to a resource that their clients—the citizens—do not otherwise have, these are not symmetrical relationships. This enables them to construct the behavior of their clients in mundane and important ways. Through their day-to-day interactions with citizens, street-level bureaucrats impart political lessons that socialize citizens in the ways of the state. For instance, even the negative act of making the dispossessed wait as they attempt to access state services has positive effects. The dispossessed learn that they have to patiently comply with arbitrariness and uncertainty (Auyero 2012).

Scholars have illuminated new directions in the study of bureaucracy. Laura Bear and Nayanika Mathur (2015) argue that ethnographies of bureaucracy should focus on the public good[2]. This is not only because the legitimacy of bureaucracy rests on the claim that it exists for

[2] Bear and Mathur define public good as denoting the complex and unresolvable tension between the desire for collective good and the reality of inequality. They push back against the economistic definition of public good as "non-rivalrous consumption" and "non-excludability," and re-conceptualize it to refer not just to clean air, roads,

public good—specifically, to materialize a social contract between citizens and officials—but also because the economization of the political in the contemporary moment, through transparency, fiscal discipline, marketization etc., is radically altering the notion of what a public good is. Bear and Mathur are writing against the moral critique or dismissal of bureaucracy that is commonplace in sociology and anthropology. Rather, they argue that bureaucratic encounters between citizens and officials are generative of affective, ethical, and even radical politics. These encounters are a central site for the forging of personhood and of collective solidarities. Scholars need to pay attention to the subtle negotiations of power in these bureaucratic encounters. How do officials and citizens pursue the public good as part of a broader conduct of life? The public good of fiscal austerity, for instance, generates new and precarious relations with the state, which may have unintended consequences for the effects of these policies. Bear and Mathur recommend that we map the diverse conflicts and collaborations that are involved in the pursuit of public goods in institutions and beyond; in other words, that we follow policies into their complex social entanglements.

Matthew Hull's *Government of Paper* (2012) brings emotions and materiality[3] into the study of bureaucracy. Hull examines how paper mediates relationships between people, places, things, and purposes in a government bureaucracy in Pakistan. Because political instability is a fact of social life in Pakistan, functionaries never know when the propriety of their actions will be called into question. This generates anxiety and makes bureaucrats "use the rationalizing regime of written documentation to ritually constitute a collective agent" (Hull 2012: 290). Through,

public education, etc. but also to desirable ideals that are considered universally beneficial, and are the rationale for radical changes to bureaucratic organizations.

[3] Hull is interested in the file—and in other semiotic technologies like chits, visiting cards, registers, plans, charts, memos, records, reports etc.—not in their role as mediators but as things in their own right, each with its own materiality. For instance, files are designed precisely to represent their history, whereas lists bear almost no traces of their production or circulation.

amongst others, the use of different signatures and stamps, passive verb forms, and the referencing of a chain of command, files are used to construct a collective bureaucratic authority and agent. This at once protects individuals and individual jobs *and* allows particular projects—questionable or illegal projects—to be collectivized. Hull demonstrates that this rationalizing practice is not driven by an intrinsic bureaucratic rationality but by the need to diffuse the agency of individuals in a very particular socio-political setting.

These studies show that while bureaucratic practices are necessary for the reproduction of the state, there is nothing straightforward or predictable about this reproduction. As Sharma and Gupta (2006) contend, the banal practices of bureaucracies—thought of as repetitive, routine, commonplace, and ordinary—are in fact anything but. These everyday bureaucratic practices are precisely what enable an ongoing state formation *from below*. However, we cannot assume these practices are smooth or inevitable. They may be resisted or subverted. They may reproduce social inequality, or they may challenge it.

In *Logics of Empowerment* (2008), Aradhana Sharma argues that the centrality of writing and written material to the Indian state is not a by-product of bureaucratic activity; rather, it is a constitutive modality of state power, one that reproduces the state, as well as caste and gender inequality. Sharma focuses on the paradoxical outcomes of a rural women's empowerment program, *Mahila Samakhya*, started as a partnership between feminist groups and the Indian government. Low caste, non-literate, and poor women participants of *Mahila Samakhya* learnt to wield the pen, and to use the same statist strategies—of paper pushing, multiple letterheads and seals, appeals to seniority—to overcome their position of systemic disadvantage vis-à-vis the state. Ultimately, the paper trails they were able to generate did not mean their requests were met, but they enabled the women to demand accountability from bureaucratic actors.

In *New Welfare Bureaucrats*, Celeste Watkins-Hayes (Watkins-Hayes 2009) studies caseworkers in two postreform welfare offices that function as "catch-all bureaucracies" in Massachusetts. She builds on Lipsky's thesis to ask, we know that discretion matters for street-level bureaucrats, but why and how? Watkins-Hayes concludes that case workers embrace one of two main organizational identities: the "social worker," who takes a holistic view of clients and is likely to bend the rules for them, or the "efficiency engineer," who takes pride in being the neutral, rule-following expert. While efficiency engineers are more valued organizationally, they not only fail to give their clients the tools to change their lives but also de-humanize their clients. Watkins-Hayes also finds that racialized professional identities overlay and complicate these models. Black and Latino caseworkers do not fit a single type; they try to be both agents of change and agents of control for their clients and draw on notions of racial solidarity to do so. They tend to share with their clients' histories of poverty and institutionalized racism. Often their job as caseworkers is all that separates them from their clients. In sum, Watkins-Hayes convincingly shows how racial identity matters in service delivery. In different ways, both Sharma and Watkins-Hayes help us understand how bureaucratic practices correspond to social structure.

ASHAs are street level bureaucrats who do paid care work. Their experiences present a unique window into some important themes in political socialization. How do states keep a workforce like ASHAs in abeyance? Put differently, how do states attain legitimacy in the eyes of their workers? What citizenship lessons, if any, do ASHAs impart to their communities in the course of their work? Do social identities of gender, caste, and class matter in these interactions? Because ASHAs perform care work for the state, in the next sections I explore the scholarship on citizenship, care, and the experiences of paid care workers.

Citizenship and care

Care work refers to the work of meeting the emotional and physical needs of children and adults. The bulk of this work is done by women, and not counted as part of the Gross Domestic Product despite its obvious contributions to well-being. Care work can be both paid and unpaid (Duffy, Albelda, and Hammonds 2013; England 2005; Glenn 2000). Care work is a social expectation of all women, and is practically synonymous with being female (Baines and Armstrong 2019; England, Budig, and Folbre 2002). Many feminists argue that care must be incorporated into the definition of citizenship[4] such that the rights to time to provide and receive care are protected rights (Knijn and Kremer 1997). Some feminists have made a case for care as a resource for political citizenship, arguing that the private values and skills associated with care can enhance the public practice of citizenship (Bubeck 1995). A broader ethic of care, not confined to women, comprises a commitment to human interdependence rather than independence (Sevenhuijsen 1998). These are normative framings that push us to consider how the relationship between care and citizenship ought to be.

[4] Citizenship is a contested concept in contemporary civil and political theory. Scholars challenge the universalism of citizenship, reconceptualizing it from the standpoint of various marginalized groups. While some prefer to view citizenship as status—involving primarily the rights of individuals—and some prefer to view it as practice—involving responsibilities to wider society, still others argue for a critical synthesis of the two (Lister 2003; Mouffe 1992). By this they mean the concept of citizenship must embrace both individual rights and political participation, including informal modes of politics, in a dialectical relationship. As Lister puts it, citizenship-as-participation is an expression of human agency in the political arena, while citizenship-as-rights enables people to exercise this agency. As such, citizenship remains a political and analytical tool of considerable value. This is evidenced in the deployment of citizenship as a framing device by a range of social movements. Feminist political theorists bring a gendered lens to bear on citizenship. While they come from different, often contradictory perspectives in their attempt to reclaim the concept, there is agreement that men and women stand in different relation to citizenship, to the detriment of women (Lister 2003). Citizenship is historically quintessentially male. Men's active participation in the public sphere as citizens is predicated on women's labor in the private sphere of the home. This public-private dichotomy has historically cast men as abstract and disembodied citizens with the necessary qualities of rationality, independence, and agency, while women have been regarded as unfit for citizenship on account of their domestic role. This dichotomy prevails today. The persistent gendered division of labor in the private sphere hinders women's access to the public sphere, and to the civil, political, and social rights of citizenship (Ibid). Women's admission to citizenship is made contingent on them mirroring men's roles (Pateman 1989).

However, as Charles Tilly (1997) notes, discussions of citizenship tend to be excessively normative, drawing on nostalgia for civic relations that probably never existed, or summoning visions of how ideal civic life can be. Tilly calls for a dis-entangling of normative themes from descriptive and explanatory ones, while acknowledging that intellectual and political issues do dovetail when it comes to citizenship.

The empirical relationship between care work and citizenship is a paradoxical one. Care work can limit, enhance, and even constitute a vital form of civic engagement (Herd and Meyer 2002). The care women provide in families requires time and money, has detrimental effects on their health, and hinders their ability to be employed outside home or participate in political activity. However, care work is not only limiting. It can also be a catalyst for civic engagement. The cooking and cleaning women do in the home enables men and later children to participate in public life. Care can stimulate the civic engagement not just of care recipients but also of care providers. Women's activism in disability rights and environmental justice movements, for example, often emerges from their desire to protect the health and wellbeing of their children and families (Ibid).

The debates linking care and citizenship have largely focused on unpaid care. This focus is understandable because of the disproportionate and persistent burden of unpaid care on women. However, states are also involved in paid care. States provide care services and employ care workers as part of the social rights of citizenship. The social rights of citizenship are described by Marshall (1950) as rights to a basic level of material well-being through state provision independent of a person's market capacities. It includes states' provisioning of health and housing, for example. States are also significant decision makers when it comes to markets and the non-

profit sector that provide care. On both these counts, how states make use of their role shapes the employment conditions of care workers (Razavi and Staab 2010).

With ASHAs, I focus on the relationship between paid care work and citizenship, particularly in the interactions between ASHAs and their communities. The dynamic between citizens and street-level bureaucrats constitutes the actual, lived character of citizenship, and is a strategic site for the examination of state power (Heller and Evans 2010). In its present historical form, the state reproduces itself through its welfare and punitive functions that reach into society (Wacquant 2009). And it is this dual function that makes the state a "vexed institution" (Scott 1998), the grounds of both poor people's domination and their survival. The experiences of ASHAs as paid care workers serving marginalized communities can reveal not just how care is extended, but also potentially citizenship.

Paid care workers

Today perhaps more than ever before, paid care work is an important arena for research and policy. Care workers now comprise a growing segment of the labor force in developed and developing countries alike. Care work refers to occupations in which workers provide a face-to-face service that develops the human capabilities of the recipient (England et al. 2002). Human capabilities include physical, mental, social, and emotional well-being and skills. Caring labor, therefore, includes the work of teachers, nurses, childcare workers, and so on. Other scholars have modified this definition to include labor like cleaning and cooking, thus covering in the ambit of paid care work the experiences of low wage workers who do the backroom work of social reproduction (Duffy et al. 2013). While *interactive* care work, also called "nurturant," is typically associated with white, professional or semi-professional women, *reproductive* care work, also called "supportive," is associated with women of color and immigrant women, and considered

more “menial.” Drawing on cross-national and country-level analyses, Razavi and Staab (2010) show that changes in economic, social, and demographic structures have accelerated the growth of care employment across countries. Public health environments, for example, create care-related needs, such as those associated with pandemics like HIV/AIDS or Covid-19.

There has long been a crisis in care. Because caring is devalued, invisible, underpaid, and penalized, it is relegated to those who lack economic, political, and social power, and because those who care are drawn disproportionately from marginalized groups, the activity of caring is further devalued, creating a vicious cycle (Glenn 2000). Scholars emphasize that care is a public good and necessitates public investment, particularly because care recipients are usually members of groups that cannot pay for care, like children, the elderly and the disabled (Duffy et al. 2013). Research on paid care in the US has shown that care workers earn less than non-care workers with comparable skills, education, and experience (Budig, Hodges, and England 2019; England et al. 2002). The care sector’s growth has contributed to job market polarization in the US, with care jobs bifurcated into low-paid reproductive care jobs, and high-paid, high qualification nurturant care jobs in medical fields (Dwyer 2013).

The research on low-wage health workers tends to be quantitative and emphasizes turnover and burnout (Castle et al. 2007; Crown 1994; Donoghue 2010; Feldman 1994; Kalleberg, Reskin, and Hudson 2000; Rosen et al. 2011; Stone 2001; Yamada 2002). More qualitative research can show us how workers experience low-level healthcare jobs in the everyday, and how they make meaning in these jobs despite their constraints (Hodson 2001; Smith 2001; Stacey 2005).

For instance, ethnographic work reveals that providing emotional care is essential to the job of low-level health workers, but this is not an activity for which they are compensated. These workers must provide emotional care by defying the rules and developing “oppositional cultures”

in which workers cooperate to provide the kind of care that bureaucratic structures do not allow (Glenn 2000). In their study of home care workers who service frail elderly people, Aronson and Neysmith (1996) find that workers routinely go beyond the call of duty to spend extra time, give gifts, and otherwise personalize their practical work. These personalizing, emotional aspects—which even workers themselves end up describing as "nonwork" or "outside the job"—make caring labor inherently or intrinsically rewarding.

Rewards are important because they help us understand the fuller experience of work, what keeps workers in their jobs, and how work can be bettered both for workers and recipients. For instance, in a longitudinal study of 261 home care aides, these mostly older women reported rewards such as the autonomy of being one's own boss and the flexibility of hours, as well as the appreciation they felt from clients, the personal satisfaction of helping clients remain at home, and for some, the relief from loneliness in their own lives (Butler, Wardamasky, and Brennan-Ing 2012). In a qualitative study, Stacey (2005) finds that rewards for home care workers come from three main sources: practical autonomy on the job especially relative to prior work in the service sector; skills building; and finding pride in work others consider dirty. While the first two are individual rewards, she categorizes the third as a relational reward, and as counter-intuitive, since workers do not internalize stigma in obvious ways but rather construct value out of the most stigmatized aspects of their work. These rewards are a mechanism through which workers import dignity to marginalized work, and at least in the short term, stay in the job despite its constraints (Stacey 2005).

The intrinsic rewards[5] of care have received attention because care is not usually associated

[5] Neo-classical economists explain the lack of extrinsic rewards in care using what England (2005) terms the "prisoner of love" framework. This view frames intrinsic and extrinsic rewards in opposition to each other, and emphasizes altruism as an intrinsic reward of care that makes up for low wages. Feminist scholars have opposed this view as class and gender biased, dismissing the notion that "anyone could live somehow above the financial

with extrinsic rewards. Using mixed methods Morgan, Dill, and Kalleberg (2013) investigate why frontline health workers both, report high job satisfaction *and* are more likely to leave their jobs. They find that the lack of extrinsic rewards (wages, benefits, career advancement) is what leads to high turnover among frontline healthcare workers, even though they report high job satisfaction as a result of the intrinsic rewards of the job, like forming strong bonds with clients (Morgan, Dill, and Kalleberg 2013).

Community health workers and India's ASHA program

The female composition of the health workforce at the primary level, where both pay and support for workers is low, reflects gender inequality. Reliance on women workers alone to run state health programs also reflects gender inequality. This reliance has the effect of institutionalizing family- and community-level care responsibilities with women, to the exclusion of men and their role in health. Such programming has been criticized for replicating gender biases while leaving power relations untouched (Feldhaus et al. 2015; Jackson, Kilsby, and Hailemariam 2019; Kok et al. 2015).

And yet, many countries' public social services have come to rely on unpaid or underpaid care work, done overwhelmingly by women, and categorized as "voluntary" or "community" work. In employing workers such that they are not counted as part of the labor force, states appear to be sidestepping their own labor regulations (Razavi and Staab 2010). Gender and development

struggles of this world" (Nelson 1999: 49). And yet, discussions on paid care work continue to carry the vestiges of this neo-classical approach. According to Nancy Folbre (2012), some of the most vital social policy debates of the last three decades in the US reflect an underlying ambivalence about the appropriate rewards for performing care. The concern that payment for care might corrupt or displace intrinsic motivation creates dilemmas in care policy. For instance, many states are reluctant to reallocate funding for elder care from nursing homes to homes and communities for fear that this will increase "demand" from family currently providing unpaid care. Similarly, public subsidies for foster care are low, especially when provided by kin, for fear that paying family to care will attract the "wrong kind" of people (Folbre 2012).

scholars note this as a trend of the feminization of responsibility and obligation (Chant 2008; Swaminathan 2015), wherein women are being made to work for development, rather than development enabling women to secure decent employment. They also point out that research on paid care work is sparse in developing countries where issues of worker insecurity and exploitation are the most glaring.

Community health workers (CHWs) are a type of frontline health workers. A community health worker is one who "receives standardized training outside the formal nursing or medical curricula to deliver a range of basic health, promotional, educational, and outreach services, and who has a defined role within the community system and the larger health system" (Naimoli et al. 2014). The use of community members to render, or connect other community members to, health services has been around for at least six decades. These programs began as part of the health and welfare movements in Western Europe and the US in the early 20th century, with middle class women "health visitors" educating working class and immigrant women about good motherhood practices (Ramirez-Valles 1998). In the 1970s, governments began to implement these interventions at the national level. In the US, CHWs have long been part of the health care landscape in states like California, Arkansas, and Alaska, and currently there are calls for scaling up the community health workforce to improve health outcomes, reduce costs, and create jobs (Singh and Chokshi 2013). Today low- and middle-income countries use CHW programs to meet their primary health care goals and to reach marginalized populations. CHW programs are driven by different regional and national priorities; in South Asia, CHWs have been appointed in response to the public health challenge of maternal and child mortality. Although no comprehensive gender-disaggregated data exists, many CHW programs are all-women by design (Schneider, Okello, and Lehmann 2016). A mixed methods study spanning India, Nepal, and Pakistan finds that CHWs are

employed by the state and work as extensions of the public health system in all three countries, but they are not recognized as such except in Pakistan (Aye et al. 2018). In India and Nepal, CHWs are not provided with a salary or employment benefits. The lack of adequate remuneration for these cadres means that effectively women from rural and poor backgrounds[6] are subsidizing their countries' public health systems (*Ibid*).

In 2005, as part of a flagship program called the National Rural Health Mission (later National Health Mission or NHM), the government of India appointed Accredited Social Health Activists (ASHAs). ASHAs are community women with at least 8 years of education, who receive 23 days of initial training and perform the following key activities: home visits, including for the purposes of pre- and post-natal check-ups; community meetings such as village-level committees on health, nutrition, sanitation; monthly meetings at primary health centers with health department personnel; outreach services in their communities such as weekly immunization drives; and, maintaining records, including birth and death registers, and other household-level data. India now has almost a million ASHAs, appointed across rural India at the ratio of one ASHA per 1000 population, and increasingly also in marginalized urban settlements (Ved et al. 2019).

Chiefly, ASHAs connect women from their communities to the government-run health system. Their primary focus is maternal, newborn, and infant mortality, and population stabilization. Their primary responsibility is monitoring pregnant women, ensuring they received pre- and post-natal care, persuading them to give birth in a facility instead of at home, and following up on children's vaccination schedules. Because the NHM is temporary but renewable,

[6] Research on CHWs finds that the lack of money is very much a problem for the workforce. In Kenya, men CHWs drop out to search for alternative sources of income because voluntary work does not allow them to fulfil their financial responsibilities as breadwinners (Kok et al. 2015). In Ethiopia, despite few or no employment opportunities otherwise, attrition among health workers is high, and unpaid overtime and low pay is a key reason for resignations (Jackson, Kilsby, and Hailemariam 2019).

all personnel hired under the NHM are contractual and not tenured employees. However, ASHAs are the only cadre of workers in the NHM to not be given the status of employees at all, not even temporary worker status. ASHAs are categorized as community health "volunteers."

In December 2013, following agitations by ASHA unions, a fixed monthly honorarium of INR 1000 (USD 14) was notified by the central government for all ASHAs. Some states announced honorariums above this level. In 2018, the central government raised this amount to INR 2000 (USD 28), paid against the completion of basic tasks like maintaining a register. Apart from this fixed honorarium, ASHAs are paid through task-based incentives. The list of tasks for which ASHAs receive incentives began with 5 in 2005, and has grown to 38 in 2017 (Ved et al. 2019). Some of these tasks are recurring monthly activities, others are one-time campaigns, so payments come from different budget streams, and payouts can be choppy or sporadic.

CONTEXT

Situated in the Northwest of India, the state of Punjab is home to a population of 27.7 million people (Census 2011). It has three sub-regions: Malwa, Majha, and Doaba. Punjab in one of the most prosperous states in India, with a per capita income that is twice the national average and a poverty rate that is the lowest in the country. With agriculture as the mainstay of its economy, the state is popularly known as "the food basket of India" (Ibid). The adoption of Green Revolution technology during the 1960s and 1970s transformed agrarian, and by extension social, life in the state. Punjab now contributes nearly two thirds to the total production of food grains, and a third to the total production of milk, in India. On account of its overall prosperity, caste[7] mobility, and

[7] Caste is one of the most significant axes of social stratification (Gupta 2004; Srinivas 1962) and has long been understood as "a specter that continues to haunt the body-politic of postcolonial India" (Dirks 2001). Scholars of caste have long refuted the classic Dumont-ian understanding of caste as ideological, village-based, hierarchical, and

low fertility (Jodhka 2004), Punjab represents a privileged case in the Indian context, and is underrepresented even in the mostly evaluative public health studies on the ASHA program (Scott, George, and Ved 2019). In sociological terms, the study of privileged or extreme cases can show processes and problems in particularly clear relief (Zussman 2004).

Dalits, or formerly 'untouchable' castes, are recognized as historically oppressed in India and entitled to quotas in public universities and employment, among other protections. They fall under the constitutional category of Scheduled Castes (SCs). Dalits constitute 16.6% of India's population. However, in Punjab they constitute 28.9% of the population, the highest among all Indian states (Census of India 2011). The sway of Brahmanical Hinduism has been weak in Punjab, because it is a Sikh majority province and before the partition of India in 1947, was Muslim-majority (Puri 2003; Ram 2012). However, this does not mean that caste is not important in Punjab. Perhaps the most tangible evidence of caste-based disparity in Punjab is in the distribution of agricultural land. Very few Dalits own or cultivate land; currently less than 5% of all Dalits in the state (Jodhka 2006).

Punjab's prosperity coupled with other significant social changes it has experienced in the post-independence period have had far-reaching implications for Dalits in the state. Dalits have used the opportunities afforded to them by the state's economic development to re-negotiate their

uniquely Indian. However, while there is consensus that caste is inextricably tied to economic and political life, and that caste dynamics have changed with shifts in the colonial and postcolonial Indian state, there is less agreement on the contemporary character of caste (Jodhka 2012). Scholars within the "ethnicization" paradigm (Brass 1984; Chandra 2004; Khilnani 1997; Weiner 1989) emphasize conflicts over access to the state and its resources, which result in intra-caste solidarity and inter-caste competition. This scholarship focuses on the public life of caste i.e. constitutional rights, reservations, electoral politics, and labor markets. Even though the significance of policing caste boundaries through the bodies of women and through practices like food and marriage is widely acknowledged, most scholars of caste—with the exception of feminist scholars—regard the realm of reproduction as private (Rao 2005; Rege 2006). In this context, there has been anthropological research on the work of lower-caste *dais*, or traditional birth attendants (see Sarah Pinto 2004, 2008; Patricia Jeffrey, Roger Jeffrey and Andrew Lyon 1989; Janet Chawla 1994).

social relations with locally dominant castes. Surinder Jodhka (2004, 2006) has conceptualized these changes through the categories of *dissociation*, *distancing*, and *autonomy*. *Dissociation* refers to the process by which many Dalits have moved away from their traditional "polluting" occupations, such as picking up dead cattle for the Chamar sub-castes. *Distancing* refers to Dalit attempts to find alternative sources of employment outside of the local agrarian economy. And finally, *autonomy* refers to Dalit investment in building their own autonomous cultural institutions, such as places of worship and community centers.

Punjab is an extreme case of social and economic mobility for Dalits in the larger context of India. Moreover, Punjab's religious composition enables a study of caste that is disentangled from Hinduism. Sharp caste distinctions survive and thrive even in religions that disavow caste. Punjab's sub-regions of Malwa, Doaba, and Majha enjoy variable degrees of economic and social advancement for Dalits and for women, allowing for a study of caste that breaks away from the identification of caste as "traditional social structure" and emphasizes instead its dynamic reproduction in different local contexts.

Unlike the Dalits of Doaba who are the most upwardly mobile and politically active of the Dalits in Punjab[8], the Dalits of Malwa have remained closely associated with agriculture, and far less mobile. In Malwa, the hold of big landowners is stronger, and job opportunities outside agriculture much lesser. While a small section of mobile Dalits in Malwa have moved to urban centers, they continue to be involved with the traditional occupation of their caste i.e. scavenging. As such, urbanization has not brought social mobility.

[8] There are a host of reasons for this. It was amongst the Dalits of Doaba that the hugely successful "ad dharam" movement for religious reform took place in the 1920s. This movement not only mobilized the Dalits against the caste system and towards a separate religious identity, it also emphasized education and entrepreneurship. Today, the Dalits of Doaba have much higher rates of education and government employment than their counterparts in other sub-regions. Doaba is also the most urbanized, and has seen the most out-migration to Western countries, of the three sub-regions (Jodhka 2004).

The district of Shri Muktsar Sahib, where I conducted my fieldwork, is one of Punjab's 22 districts. This predominantly rural district has the highest percentage of Dalits—42.3 percent—of any district in Punjab (Census 2011). At the time of my research, there was no caste disaggregated data on ASHAs in Muktsar, but from what I could gather, Dalit ASHAs were in a majority. This is not unusual given that the government attempts to match ASHAs to the community they serve. The average monthly payment made out to ASHAs in Muktsar then was INR 2700 (approximately USD 39). In March 2019, Punjab declared that the monthly minimum wage for a skilled worker is INR 10129 (approx. USD 145) (Dept. of Labor Punjab). 'Skilled worker' is the statist category under which ASHAs would fall if they were to be recognized as workers, but as things stand, ASHAs are considered volunteers and not employees of the state.

Muktsar's workforce participation rate for women is 14.7 percent, which is lower than the national rate of 27.4, already one of the lowest in the world (Census 2011). Despite rising incomes and structural transformation, women's labor force participation rate (LFPR) in India is declining. India is unusual but not unique in this trend; Turkey, Indonesia, and Ghana face a similar problem (Chatterjee, Desai, and Vanneman 2018). The reasons for this are manifold. Women have been pushed out of agriculture because of the mechanization of specific labor processes like threshing and winnowing. However, with low education and skill levels this group of women is unable to compete for jobs in the manufacturing and service sectors. From 2004-5 to 2011-12, the size of the labor force for women from marginalized groups—including Scheduled Caste or Dalit women—declined by seven million (Mehrotra and Parida 2017).

In the case of ASHAs, there are countervailing influences on India's low employment rates for women. ASHAs in Muktsar are married, mostly household heads themselves or the spouse of household heads, and mostly non-upper castes; these characteristics are associated with higher

LFPR (Chatterjee et al. 2018). Moreover, jobs in social services like health and education are one sub-sector where female employment is either growing or constant (Sarkar, Sahoo, and Klasen 2019). Essentially then, the question of why a variety of women continue as ASHAs both with and without employment alternatives remains.

The 1990s marked paradigmatic shifts in Indian polity, with the state undertaking neoliberal reforms. At the same time, reservations (the affirmative action policy, also known as quotas) were extended to a new social coalition of mid-level castes, termed the Other Backward Classes[9]. Also, since then, welfare programs have been expanded and new social and economic rights—to food, education, and rural employment—enacted. Some scholars see these shifts as class and caste "abatement" (Gupta 2005; Jayal 2015) in a democratic society that is restructuring for industrial interests. Nonetheless, Dalits in particular have gained from the increase in state spending on public goods. This includes more accessible school education, health, piped water, and electricity. It also includes "government work" at national minimum wage, created in the world's largest work-fare scheme, the National Rural Employment Guarantee Act. Apart from these expansions, in general too, Dalit men and women show preference for public sector jobs (Mosse 2018). This is unsurprising given the lack of access, capital, networks, and the discrimination Dalits contend with in private sector jobs or self-employment. This does not mean, however, that the delivery of public services is without discrimination. Studies of rural health care, school meal programs, and subsidized food grain distribution also report caste-based segregation, avoidance, and untouchability (Ibid).

[9] Other Backward Classes: an official category but added to the constitution later, comprising of mid-level castes (non-upper caste and non-Dalit) determined to be socially and educationally disadvantaged.

Because ASHAs are not state employees, there are no caste quotas for their recruitment. And yet, there was no upper-caste capture of the ASHA posts in my field site. The reason everyone gave me for this—from officials to the ASHAs themselves—was the low-wage, low-status nature of the work, and the extensive outreach it involves with marginalized communities.

METHODS

During preliminary fieldwork in the summer of 2017, I was able to secure permission for fieldwork from the Ministry of Health and Family Welfare in Punjab's capital, Chandigarh. This was the result of a surprisingly pleasant meeting with the state nodal officer for the ASHA program. I found the officer to be warm, helpful, and open-minded. She told me she would put me in touch with the coordinator for whichever district/s I selected in Punjab, and had useful suggestions for how to go about the research. We decided I would be issued an official letter when I was back for fieldwork the following year.

Excited about this carte blanche I had been given with district selection, I reviewed census data in earnest and found that Muktsar and SBS Nagar were two districts in Punjab that had near identical caste compositions (high Dalit percentages) but varied in prosperity. Muktsar was in the more rural Malwa region with poorer literacy rates and sex ratios, while SBS Nagar was in the more urbanized Doaba region with higher literacy rates and a balanced sex ratio. I decided to do six months of ethnographic fieldwork in Muktsar, and three months in SBS Nagar, in order to compare caste and class in ASHAs' experiences. I ignored the advice I was given to stay in one location, so as not to make the ethnography long and unwieldy. But this turned out to be the right advice. Once in Muktsar district, where I had decided to live first, I realized I had underestimated how long it would take to become familiar with my coordinates in a new place and establish rapport

with my participants, to say nothing of the emotional exhaustion of fieldwork. I decided to stick to Muktsar, and to focus on another variation that seemed meaningful from the ASHAs' point of view, and mapped somewhat onto class: rural and urban.

The ethnographic method is ideally suited to study the everyday life of states because it draws attention to processes both mudane and important (Sharma and Gupta 2006). Even the difficulties in conducting my research, I found, were conceptually illuminating about state power. The first month of my fieldwork yielded two problems: one, I was waiting on the letter of permission to be emailed from the capital to the district, which took longer than expected. This was not a problem in the rural block, because the medical officer in charge of that block was a friend of the family I was living with. But the officer heading the urban block regarded me with some suspicion, and insisted on the letter. This was my first lesson in the importance of affective ties. My ability to conduct fieldwork was constrained till I secured *formal* permission, but only where *informal* ties did not override this need altogether. Second, ASHAs routinely mistook me for a journalist or a government official from Delhi who was conducting a "check." As a result, they were reticent with me. I spent many initial weeks waiting to hear back from people. In the second month, something shifted rather fortituously. The local ASHA union that had been dormant for some time was revived, and I began to tag along for their meetings and protests. This seemed to reassure some of the ASHAs that I was not part of, or answering to, the state machinery, and we became friendly. These friendships were later instrumental in helping me access and make sense of the social lives of ASHAs for the rest of my time there. This experience made me realize that to study the state without appearing aligned with it is a methodological challenge.

I conducted 14 months of ethnographic fieldwork (June-July 2017, and then July 2018 to June 2019) on the ASHA program. I lived in Muktsar continuously from July 2018 to February 2019, after which I moved to my parents' home in Delhi and visited Muktsar on and off till June 2019. I visited Muktsar again in December 2019.

While in Muktsar, I did field observations and interviews (n=60) with ASHAs across an urban and a rural block in Muktsar that I do not name in the interest of de-identification. Additionally, I conducted interviews (n=20) with officials and experts on the ASHA program, at the district, state, and national levels. Some of these interviews were of district-level officials in Muktsar, and others were of officials, academics and activists in Chandigarh and Delhi.

Because ASHAs are positioned as links between their communities and the health system, I followed ASHAs as they interacted on both these ends. I observed ASHAs as they toured their areas, conducting pre- and post-natal visits, updating their registers, reminding women about their vaccination schedule, persuading women to come to the hospital for tests, and so on. I attended EPIs (Extended Program on Immunization) nearly every week in the beginning, and less so later. EPI is a weekly (sometimes biweekly, depending on the population) vaccination drive, when nurse supervisors make themselves available in a community space like a temple or the local health center, to vaccinate children and expecting mothers. ASHAs are key to EPIs, although they do not administer the vaccines, because they call or round up women as per women's vaccination schedule, and help with handling children, not to mention arrange tea, chairs, carry the vaccine supplies, make register entries etc. Whenever possible, I would attend other community-facing events: the pulse polio vaccination drive, outreach camps in marginalized urban areas, the Village Health Nutrition Sanitation Committee meeting of which ASHAs are part. With time, as I became close to some ASHAs, I would hang out in their homes a lot, or around town, getting chai and

snacks, shopping, visiting the temple, attending the annual local fair[10]—whatever the women were doing—and participating in their lives in every way I was invited to, including watching films, planning a child's birthday party, attending a *keertan* (devotional gathering with music and dance), and so on. As the ASHA union gathered steam, I attended their meetings and protests, including accompanying Muktsar's ASHAs to a protest planning meeting, following by a state-wide protest, both in towns outside Muktsar.

I also followed ASHAs in their interactions with the health system. I attended ASHA trainings; these are periodic on-the-job courses and refreshers where ASHAs upgrade their skills by learning about new topics in health care. They usually run for 3-5 days, for a group of 30 to 40 ASHAs at a time. I also attended meetings; these were usually monthly meetings of ASHAs and/or nurses in the rural block. The Senior Medical Officer of the rural block, along with her block-level staff, would run these meetings, issuing reminders for submissions, instructions for upcoming campaigns, and other kinds of trouble-shooting related to work. The urban block did not have these meetings. I would hang around the postpartum unit of the civil hospital, which the urban ASHAs frequented almost daily. This made me privy to several informal meetings and conversations between ASHAs, their nurses, and other staff. Being in the hospital so much also gave me the opportunity to observe how ASHAs service their patients, guiding them about next steps, where to go, filing paper work, or checking on the women (and their families) who are in the ward, waiting to give birth, or having just given birth. I observed ASHAs as they navigated payments: they would sit with their nurse supervisors to prepare monthly reports by tallying their activities for the month which would be added up to determine payments for that month. This could involve some back-and-forth, and sometimes ASHAs met with staff in a group if payments were unsually

[10] Muktsar's Maagi mela is much more than a village fair; it is a significant religious and political event in Punjab that goes on for a month and attracts thousands from around the state.

delayed. I also observed ASHAs as they got pulled into health department events, such as an awareness march through the city, or a public speech by a senior doctor for World Health Day.

In the first few weeks of fieldwork, I made notes in a notebook. But I sensed this made people uncomfortable. I would often be asked what I was writing. I decided to stop doing this. If something needed to be noted down urgently, I would email it to myself on my phone. This attracted less attention. For the first three months of fieldwork, I would type out my fieldnotes at the end of the day or the next day. But somewhere in the fourth month, around the same time that I began conducting interviews, I would feel too tired to type in such detail. At that point, I began to audio record myself, and continued to do so till the end of fieldwork.

From a list of all ASHAs in the rural and urban block, I sampled equal numbers of Dalit and dominant caste ASHAs to interview. In the dominant caste category I included roughly equal numbers of General category and OBC ASHAs. Within these categories, I conducted snowball sampling, so I could include ASHAs I had built rapport with, as well as ASHAs with certain experiences that seemed inductively important, such as ASHAs who were applying to be nurses, or ASHAs who had contested local elections. I was assisted in my sampling by the ASHAs I was close to, especially the ASHA I call Preeti. Preeti has been a rural ASHAs since the posts were created, but began to live in the urban block some years ago. On account of her experience in both settings, and because she is an office bearer in the ASHA union, she is extensively networked. She asked me one day who exactly I was looking to interview, because many ASHAs wanted to be interviewed (especially once word got out that I was compensating for interviews). I explained to Preeti that I was looking for variation in experiences, a concept she understood easily. She told me about variables far beyond the official lists I had received (which included caste and education). She told me which ASHAs were young and which old, who was active in the union and who was

not, who was married to local doctors or doubling up as a local doctor, who was earning more or less, who had fought with her nurse (one had taken a nurse to court), who had political ambitions, who used to be a dai (traditional birth attendant), who used private hospitals a lot or not, and even women who were ASHAs and had now left the role. Needless to say, Preeti was instrumental to how I navigated the field, but especially the interviews.

		Scheduled Castes		Dominant Castes	
	Overall	Urban	Rural	Urban	Rural
Age	36.9	37.6	34.3	35.9	39.7
Religion:					
Hindu	21.7%	20%	0%	46.7%	20%
Sikh	78.3%	80%	100%	53.3%	80%
Education:					
8th standard	16.7%	13.3%	33.3%	0%	20%
10th standard	55%	40%	46.7%	66.7%	66.7%
12th standard	21.7%	40%	20%	20%	6.7%
More than 12th standard	6.7%	6.7%	0%	13.3%	6.7%
Household size (mean)	5.4	5.3	5.8	5.4	5.1
Live with husband	85%	86.7%	73.3%	86.6%	93.3%
Number of own children	2	2.6	2.1	1.7	1.6
Live with other-relatives	48.3%	33.3%	60%	46.7%	53.3%
Household income-monthly (USD)	207	169	235	192	230
Years in ASHA	5.3	3.4	6.6	2.3	8.9
First job outside home	78.3%	40%	100%	80%	93.3%
In union	80%	93.3%	73.3%	80%	73.3%
Additional education as ASHA	21.7%	20%	26.7%	13.3%	26.7%
Population size assigned	2,080	3,260	1,312	2,647	1,128
N	60	15	15	15	15

Table 1: ASHA interviewees

As a young, urban, unmarried, upper-middle-class woman of mixed ethnicity, I was an outsider to my field in most senses. This generated curiosity, and required me to field questions of a personal nature with some openness. However, my father is Punjabi (he grew up in an adjacent

district), I have a recognizable Punjabi surname, and I was living with extended family who also ran a local eye hospital of some repute; I leveraged this information to make myself socially legible to my participants.

In my interviews with ASHAs (lasting from 30 to 90 minutes) I asked questions about their work history, selection into the ASHA role, and experience of trainings; knowledge of public life and networks in public and private hospitals; the details of their work, barriers to their work, and how they overcome these barriers; experiences with women from within and outside their castes; reflections on the impact of the ASHA role on their lives and recommendations for the program. I compensated ASHA interviewees a standardized amount for time/wages lost and travel costs incurred. Interviewees signed two copies of a consent form, which I went over in brief verbally as well, one copy for themselves and one for me.

One of the first ASHAs I interviewed became a close friend. I call her Navdeep. Navdeep told me that many ASHAs get into fights with each other over patients, and with ANMs, Auxiliary Nurse Midwives, over payment. She recommended that I add two more questions to my interview schedule (do you have any problems with other ASHAs over your area? And do you face any difficulties with your ANM?) which I did. I am grateful to her for this. Navdeep and Preeti underline for me that qualitative data is co-produced with research participants.

During their interviews, I found that ASHAs mostly complained about the constraints and difficulties of their role. This was due to several reasons. ASHAs are faced with the strenuous task of linking marginalized communities to an overburdened and sometimes hostile health system, a task made even more strenuous by ASHAs' precarious occupational status as incentivized volunteers. Put differently, ASHAs have a lot to complain about. Moreover, ASHAs were surprised that I—an obvious outsider—had come "all the way" from Delhi or America (depending

on what they had heard). Despite my clarifications that I was a student doing research, they were convinced that I might be able to advocate for them in some way. They would insist, for instance, that I write in my "report" how hard they worked and that they deserved salaries. As a result, ASHAs were less forthcoming about the rewards of their role. Nonetheless, I found their responses to certain questions very instructive regarding rewards. These questions were: what has changed in your life since becoming an ASHA, what is the best part of being an ASHA; can you tell me about one moment when you felt very happy or proud that you are an ASHA; and would you recommend this role to others. Additionally, many interviewees did not want to tell me about the income they earned apart from wages—side hustles and private hospital commissions—lest I think they have plenty of spare time and/or are doing something they are not supposed to. I would find out details over time, as my familiarity with the field and with some ASHAs grew. This is where the long-term and immersive quality of ethnographic research was productive.

In order to map the conflicts and consonances between the views of those who run the ASHA program, and the ASHA themselves, I conducted expert interviews, and also attended two conferences organized by activists of the people's health movement in India. Some of these interviews were much harder to secure than others, and it could be weeks, sometimes months, before I was given an appointment. Most notably, respondents who were in government or working very closely with the government were not prepared to be critical on record. They would speak more freely once the recorder was turned off, requesting of course that I do not quote them.

After fieldwork, I began the process of coding my interviews and fieldnotes in ATLAS.ti to identify recurrent patterns and exceptions of interest. Because my data is in three languages—English, Hindi, and Punjabi—I do not transcribe everything, just the material I am using. To preserve anonymity, I use pseudonyms.

CHAPTERS

In the first chapter, I show how the social profile of women who are ASHAs intersects with their occupational status—"incentivized volunteer"—to compound their vulnerability as workers. ASHAs, described to me as "needy women," are overwhelmingly poor, lower caste, with low educational attainment, and struggling to provide for their families. Their work is central to the running of the health department, but the discourse of service (volunteerism) undercuts their rights as workers. I find that the system of incentive payments, to which ASHAs are uniquely subjected, creates conditions for chronic underpayment and control of ASHAs. Incentives do not exist for all the work ASHAs do, and where they do exist, they are not always paid out owing to confusion among staff. Incentives also engender relations of fealty with nurse supervisors who determine ASHAs' monthly payments. Nurses exercise a great deal of discretion in the working lives of ASHAs. This discretion is not always bad. But it points to how the incentive payment system is essentially a lever through which the health department can control ASHAs, often making them do more work than is their brief. Because ASHAs need patients to earn incentives, this system also creates competition among ASHAs for patients, resulting in fights over area. For these reasons, I argue that the incentive payment system is much more than form—an alternative to giving wages as salary—it is also content—the constitutive modality of ASHAs' work. It is a new way to lower the wages for care and institutionalize the devaluation of care.

In the second chapter, I follow ASHAs into their communities. To secure patients, ASHAs perform what is usually represented as 'gossip' but what I call 'motivational labor,' that is, they forge and sustain intimate relations with other women in their communities. I explore what relationship building requires of ASHAs: emotion management, time, and money, as well as a mix of insider sociality and discretion. Motivational labor builds trust, without which ASHAs

recognize they cannot fulfil their assigned tasks. Motivational labor is inversely proportional to what I call 'motivational capital'. The more an ASHAs' motivational capital, the less motivational labor she needs to perform to persuade those under her care. ASHAs may have more or less motivational capital depending on how long they have been in the role, and how familiar they are with the area under them. The most salient feature of motivational capital, though, appears to be caste. However, this is not a simple equation, where upper caste ASHAs are able to motivate all castes. Motivation is relational. It depends on whether there is a match between the caste of the ASHA and the caste of the care recipient. Scheduled Caste (SC, or Dalit) care recipients are the easiest to motivate for ASHAs from all castes. This relationship is moderated by education and class. For instance, daily wage earning SCs are harder to motivate. The hardest to motivate, though, are upper caste (or General category) care recipients. This is true for ASHAs from all castes. But this also where motivational capital matters. SC ASHAs have less motivational capital with upper caste care recipients than upper caste ASHAs, and end up doing more motivational labor.

Despite the difficulties of their role on both ends—with the community and the health system—women persist, even thrive, as ASHAs. In the third chapter, I explore why this is. I find women experience many rewards as ASHAs. These include intrinsic rewards usually associated with care occupations—flexibility, skill building, dispositional changes, emotional gratification—but also extrinsic rewards—income and career advancement—not usually associated with care occupations. I find ASHAs are able to use the proximate ties they form with women and families as social capital. This is critical to their success. It enables them to earn not only through wages but also through unofficial income streams: side hustles and commissions. However, there is a flipside to proximity. As community health workers who earn through incentives, ASHAs live among and need their patients in a way that other health personnel do not. Their communities hold

them accountable for health outcomes, but the health system affords them no power to control these outcomes. This puts ASHAs' reputations at stake, and their mental health under chronic, often acute, strain. In this chapter, I explore the dualistic nature of proximity that creates rewards through a rather punishing relationship for ASHAs.

In the fourth chapter, I show how ASHAs become agents of political socialization. ASHAs are socialized into, and socialize others into, the ways of the state. Despite their circumstances, ASHAs convey a sense of attachment to the state. Here, I explore how this attachment comes to be. I find ASHAs are responding to what I call the 'promissory capital' of the state. Women become ASHAs because they believe the role is, or will become, a tenured government job. And while this has not happened, the state keeps its promise alive in the everyday by making small overtures to ASHAs. Promissory capital indexes a mechanism; how a hollowed-out state nonetheless attains legitimacy in the eyes of its workers. I also explore how ASHAs expand the social citizenship of their communities, by bringing them into the fold of the state, particularly of welfare services. The existence of welfare programs is a necessary but not sufficient condition for the expansion of social rights. Communities need to know how to access these programs; they need the right information *and* the right disposition. This is where ASHAs come in. I also find that some women expand their own political citizenship through the role of an ASHA—by becoming union leaders and contesting local government elections.

More and more, ASHAs are blamed by health officials for diverting patients to private hospitals. In my fifth and final chapter, I show that while this picture is not inaccurate, it certainly is incomplete. ASHAs operate within an ecology of health delivery characterized by private sector capture of the state at various levels. One example of this capture is an important figure in my field, a senior health official, whose "public private partnership" with her husband I explore here.

In general, ASHAs' private sector links are encouraged, even required, by how India's public health system is organized. The courting of ASHAs by private hospitals is widespread, aggressive, and fairly successful. But it does not necessarily follow that ASHAs act against patients' interests; after all, ASHAs rely on their patients. What the courting does reveal, however, is the extent to which the private sector is embedded in the public sector, and relies on the state (in this case on ASHAs as state agents) for its expansion and continuation. In essence, ASHAs draw benefit (and blame) while being caught up in a web of health delivery that is not of their making.

Chapter 1: "Needy women"

"Luckily for you, Muktsar district has Sukhdev. Not everyone in government is so sincere, so hardworking."

Back when I sought permission for my research from the person in charge of the ASHA program for Punjab state, she used these words of high praise for her supervisee Sukhdev. Sukhdev is a district-level officer in-charge of the ASHA program in Muktsar, one of Punjab's 22 districts. She was right. Sukhdev was my first guide to the field. In his late thirties, Sukhdev is clean-shaven and slightly cherubic in appearance, and has a polite manner. He would painstakingly, repeatedly explain to me everything ASHAs do, and who is who in Muktsar district's health administration. Sukhdev's official title is community mobilization coordinator. In this role, he oversees all of Muktsar's ASHAs, about 400 in number, and is responsible for their trainings—up to eight modules plus refreshers, a grueling roster.

In my early weeks, I would constantly show up at Sukhdev's office with questions. He humored them all with a patient, sometimes tired, smile. Sukhdev sits at the office of the civil surgeon, the highest-ranking medical officer in the district. This office, conveniently, was a short walk from where I was living. I couldn't help thinking I must have cut a strange figure to Sukhdev being so obviously urban and upper-middle-class, showing up in a place like Muktsar, overwhelmingly rural and in Indian parlance, "backward." But if he wondered, unlike his colleagues who joked they had seen people leave Punjab for America but never the other way around, Sukhdev didn't show it.

It is our first-ever meeting. He sticks to talking about what I need from him. He tells me he can pull up the recent incentive payouts made in the district, so I can determine the "active" from

the "non-active" ASHAs. How so, I ask, not quite following. The ASHAs who earn more incentives are active, and the ones who earn lower are inactive, he explains. I ask if he has data on ASHAs' castes. He does not, but he offers to get it. "All the ASHAs are mostly SC[1] (formerly untouchable castes), then BC[2] (mid-level castes). There are very few General[3] (upper castes). The General ones don't work. And the effort is to match ASHAs to the community. ASHAs have been appointed for under-served populations right. As much as possible, we give the role of an ASHA to women who are needy. Someone who is widowed, or disabled, you know?"

I furiously took notes in my field diary, setting the tone for all our future meetings, as Sukhdev became my go-to man for navigating the field. There is a lot to absorb when you are trying to understand the behemoth that is a state-run program. I felt overwhelmed with information. Even so, this sentence stood out "As much as possible, we give the role of an ASHA to women who are needy." I associate the word needy with dependence and clinginess in personal relationships, stereotypically feminized. Like a needy girlfriend. But here, by needy, Sukhdev means people in need of support, impoverished. The ideal candidates for the role of an ASHA—the disabled or widowed women from among SC and BC communities—are needy on account of who they are (ascriptive identities) and what befalls them (circumstance). The neediness is non-volitional. Its nature and machinations are obfuscated, or beside the point. It just is.

The term needy stays with me. And I have many occasions to reflect on it.

One such occasion presents itself within the first month of fieldwork, fairly soon after Sukhdev used the term. At 10 am on a sunny morning, I am at the civil hospital, the topmost public

[1] Scheduled Castes: a constitutional category comprising of Dalits or formerly 'untouchable' castes, recognized as historically oppressed and entitled to quotas in government education and employment, among other protections.
[2] Other Backward Classes: an official category but added to the constitution later, comprising of mid-level castes (non-upper caste and non-Dalit) determined to be socially and educationally disadvantaged. I use BC and OBC interchangeably as acronyms.
[3] General or unreserved category refers to the unmarked upper castes who are not eligible for government quotas.

hospital in the district. I have picked an urban and a rural block (administrative units within a district) of Muktsar for my fieldwork, and this is the former. I am looking for Kamla. Kamla is 48 years old, and joined as an urban ASHA in 2015 when these posts were created. She is wiry looking, with a lot of nervous energy and eyes that dart about when she talks. Kamla has been a godsend for me. She is unassuming, open, and the first ASHA to invite me along on home visits with her. Today she is at the civil hospital filing her "monthly report" – a list of incentivized tasks completed for the month, on the basis of which the ASHA's payments for the month are calculated. I want to see how this is done.

I find Kamla standing in the corridor outside the postpartum (PP) unit, together with Japneet and Roop, also ASHAs. Kamla, Japneet, and Roop share a nurse supervisor, and their areas are adjacent neighborhoods in the city. We greet each other. I ask what is going on. Immediately they all start complaining. It is 27th August 2018, but their payments for July have still not come through.

Japneet says, "How are we supposed to run our homes, pay our bills? I am widowed, she (points at Kamla) is fighting a court case against her husband for abandonment (Kamla looks at the ground blankly), her husband (nods her head at Roop) is without work. They should at least give us some money for transport." She calculates that it can cost her Rs. 80 if she is to make a round trip to the civil hospital, and another to her area, in a single day (Rs. 20 each way). Japneet, like many urban ASHAs, has been assigned an area in the city that is not the neighborhood where she resides, so she must travel to get there.

Japneet drops her voice dramatically and leans in. She adds, "When they want work from us they say 'you are staff, you are part of this hospital, if you work well, you will earn all of us a good name.' And when it comes to paying us? When we ask about the delays they say, 'It's not

like you are staff.' Our work is so hard. We have to run around so much. In the heat! It is not easy! But this is how it works here: the highest person has the easiest job. The SMO (Senior Medical Officer, highest block-level officer, in charge of the civil hospital), he sits in an airconditioned room, he doesn't have to go anywhere, he just summons people when he needs them, and he gets the highest salary. And us? We do all the running around. We don't even have vehicles. These nurses, (slows down and speaks with emphasis) despite having vehicles don't go to their areas. Who goes? We go."

Now it is Kamla and Roop's turn to chime in. "Look, there is no room for us in this hospital to sit in. We have to wait here, outside." She is right, we have been standing the whole time. They are talking about the postpartum unit, a room with about 10 chairs, where the nurses and their big boss, the Lady Health Visitor[4] (LHV) sit. The LHV has a volatile temperament. When she is in a good mood, she banters with the nurses, they share food and swap stories, and ASHAs sit around and participate as well. But her sense of humor is bizarre—she makes cracks about knowing your neighbors well, a dig about promiscuity I realize later—and her temper is mercurial. She gets annoyed quickly and unexpectedly. I have seen her put ASHAs to all kinds of work, like refilling her water bottle at the hospital cooler, or getting her tea from the canteen outside. Often when ASHAs enter the PP unit, she will ask them to leave. She says "overcrowding" makes her feel claustrophobic. There is a four-seater steel bench in the corridor just outside. This is where ASHAs end up gathering. We are standing a little away from it as we have this conversation. Kamla is not done complaining. The indignities for ASHAs are not limited to being thrown out of the PP unit.

"Sometimes when we come with women who are going to deliver their babies, we have to stay the night, sometimes a couple of nights. We sleep on the floor, next to the patient's bed. The

[4] LHV is Lady Health Visitor. In the hierarchy, ASHAs report to nurses with the title Auxiliary Nurse Midwife (ANM) and ANMs to the LHV. There is one LHV in the urban block, and several in the rural block.

SMO says, we might not have place for you in the rooms but there is always place for you in our hearts. Is this correct?!" she asks with incredulity. Roop and Japneet shake their heads, lips pursed.

As the lowest rung of the health department, Japneet, Kamla and Roop are well-positioned to see how their labor undergirds the working of the department but is nonetheless sidelined by it. Japneet stresses the 'neediness' of the trio to make a moral appeal for what should be theirs by right: fair and timely pay. But far from making the department do right by them, their material circumstances seem to lay the groundwork for their exploitation. She knows this too.

The rest of her rant details the double standard of the department—the gap between their words and actions towards ASHAs. When the department needs the ASHAs to work, it flatters them. This was evident to me from all the department meetings I attended, where senior hospital staff would call ASHAs the "backbone" of the health department. But ASHAs have been assigned a liminal occupational status that makes them partial outsiders to the department. As "paid volunteers," they are easily disregarded by staff. ASHAs do not even get a room of their own. The lack of space signifies their lack of status in the state. In fact, the LHV's behavior towards the ASHAs is a diagnostic of their status: she wants them to run around for her, but she doesn't want to share space with them. The SMO's comment to Kamla is revealing of how ASHAs are viewed by health officials; when he tells Kamla that they might not have space for ASHAs in the hospital, but ASHAs have a space in their hearts, he is saying there may not be physical space to accommodate them, but there is emotional appreciation of their labor, and that *that should be enough*. The SMO's comment is symptomatic of an altruistic imagination of care work: because care work is emotionally rewarding, material rewards do not matter. Many in the health department share this view. In another interaction I witness between the LHV and a group of urban ASHAs who bring up payment delays, the LHV reminded the group that they were here to do service.

Quoting a common Hindi idiom, she asked them to focus on their work and not its fruits, and to have faith that god would repay them.

I found that a large number of ASHAs are struggling to fill the role of provider for their families. ASHAs must be married as a rule—because most of India is patrilocal—but many ASHAs are either widows, or have been abandoned by their husbands, or have husbands who are drug users (Punjab's drug problem has reportedly reached epidemic proportions). In each of these cases, women have to cope with the failure of what I call the heteronormative promise. Women are raised with the promise that marriage to a man is inevitable and desirable, and once married, he will provide. She will raise a family, maybe do supplemental work at most. Since women are not raised to be providers in the manner of household heads, they are not educated or skilled enough to be competitive in the labor market. But heteronormativity has not upheld its promise. The reality of their lives has pushed them to work outside the home, to support their families financially. This makes them "needy" in the way Sukhdev described. And while the intent with which needy women are chosen as ASHAs may well be benevolent, its effect is the creation of a workforce that is docile and desperate. Always, already exploitable.

INCENTIVES AS UNDERPAYMENT

I am in Sukhdev's office once again. This time, I want to clarify exactly how much ASHAs are paid, and for what tasks. There is a long list of incentives for ASHAs for different activities, ranging from the activities for which they were originally appointed, like hospital births, to activities that have been added later to their workload, like screening households for non-communicable diseases. I wait for Sukhdev to get off his cellphone. When he hangs up, he clears his throat as if to indicate I have his attention now. He explains routine incentives to me:

> Today, even if an ASHA does no visits, she can make a basic payment of Rs. 1150 (USD 17) a month. Let me break this number up for you. One, she has to maintain a register at home, updated monthly, that records household details for the area in her charge, like number of members, age, sex, chronic disease; birth and death; what we call a 'due list', that is, a list of children and pregnant women who are due for vaccination; eligible-to-birth couples, defined as couples 18-45 years of age who use no permanent method of family planning. Once the supervisor checks this register, the ASHA gets Rs. 500 for it (USD 7). Then for attending weekly immunization drives, what we call EPI,[5] she gets 150 (USD 2) per month. Then another 150 (USD 2) to attend the VHNSC[6] monthly meeting, which a village health and sanitation meeting. Then to attend the monthly meeting in the health center where they report, they get 150 (USD 2). Then on Village Health and Nutrition Day they get 200 (USD 3); they can convert any one weekly immunization day into this.

He pauses here. It is probably to help me write it all down, since he is speaking at a steady pace.

> Now on top of this basic pay, they get 600 (USD 9) for antenatal visits–this involves four checkups or visits to a pregnant woman, giving her iron-folic acid pills, checking her blood pressure, weight, having her hemoglobin levels tested. The incentive to have her give birth in a hospital is 300 (USD 4.5). For getting a pregnant woman registered: 50 (USD 1). For completing postnatal checkups, 250 (USD 4): this involves seven visits to a new mother if she gave birth at home, and six if she gave birth in a hospital, up to 42 days after the birth. Then there is incentive for having a child immunized: at the nine-month mark, ASHAs get 100 (USD 1.5), at the two-year mark they get 50 (USD 1). Add all this up, and depending on the size of the population under her, an ASHA can make a maximum of Rs. 7000-8000 (USD 100-115) a month, but the average is 2600-2700 (USD 38).

[5] EPI is Expanded Program for Immunization, used as shorthand for the weekly immunization day—usually Wednesdays unless they have to be pre or postponed on account of a holiday—conducted by ANMs and ASHAs. In some urban areas EPIs are as frequent as twice a week, with the second day being a Saturday, and in rural areas they are conducted once in 2-3 weeks.

[6] Village Health Nutrition and Sanitation Committee, of which the ASHA is member-secretary.

The incentive structure sounds very complex to me, and public health's propensity for abbreviations does not help. I have been told the daily wage labor rate for agriculture in Punjab is Rs. 300 (USD 4.5) a day, making the monthly earning of an agricultural laborer three times that of the average ASHA. This is a surprisingly low amount. But I soon learn that more than the amount, the *format* of ASHA payments is extremely problematic.

I run into Sheenu at the tea stall at the entrance of the civil hospital one morning. Sheenu is an ASHA in the city, a 30-year-old single mother of two. After a string of scorching days, it is a bit cool today. I remark to Sheenu that it is such a good day. Sheenu cuts me off: "What good day? My nurse has ruined my mood." I inquire why. "She struck off one antenatal checkup incentive from my monthly report. The woman had delivered a stillborn child. So the nurse said to me, what care are we paying you for, if the child didn't make it?"

ASHAs file their monthly report together with their nurse supervisor. The nurse must sign off on the tasks completed by the ASHA for any given month, and how much the ASHA will be paid for that month is calculated by totaling the incentive for each of these tasks. Only the tasks that are validated by the nurse make it to this monthly report. Sheenu is upset because her nurse supervisor has struck off a payment Sheenu was expecting will be approved. The nurse supervisor pegs the incentive for a patient's antenatal checkup to the birth of a live baby. Technically, this is incorrect. The rule is that Sheenu should still be paid for the visits she made. But nurses do not always have clarity on the conditions that have to be met in order for an incentive to be approved. In the course of my fieldwork, I commonly witnessed nurses asking Sukhdev to go over the list of ASHA incentives with them. This happens also because incentives frequently change—amounts

can increase or decrease, and tasks can be added or removed, depending on what higher-ups in the government prioritize or de-prioritize.

This confusion is not limited to nurses. ASHA incentives can be confusing for other staff in the health department too, with consequences for ASHAs. This is an excerpt from a focus group discussion I conducted with nurses:

> Whatever ASHAs earn is because of their hard work. They should get that money. But a lot of the staff does not understand what ASHAs do, how much they work. Sometimes a pregnant patient reaches the hospital for delivery, but the patient's ASHA does not reach with her. The ASHA may be ten minutes behind, twenty minutes behind. The staff on duty will ask, is your ASHA here? The patient will say, no. The patient gets nervous right? The staff will write in the file, 'no ASHA.' That's it! The ASHA will not get her hospital delivery incentive. But the ASHA has chased that patient for nine months, she has motivated the patient to deliver in the government hospital. But no! If the file says 'no ASHA,' then the ASHA gets no incentive.

Even when they have earned it, ASHAs do not always receive incentives, for various reasons. But there is another thing: for a lot of the work ASHAs do, there exists no incentive.

On September 18th 2018, I accompany two nurses to a government-run school in a village. The nurses are there to conduct a round of DPT (Diphtheria, Pertussis, and Tetanus) TT (Tetanus Toxoid) immunization. This is routine stuff. The ASHA for this village is Jaspreet, someone I have seen around. Jaspreet is an active member of Muktsar's recently revived ASHA union, so I have run into her at union meetings. She is always crisply dressed, and commanding and articulate when she speaks. She has an air of quiet dignity that I am instantly impressed by.

To attend the immunization, I travel to the village school with the two nurses, the three of us riding tight on one scooter. Jaspreet comes on her own scooter, a couple of minutes after us. It turns out to be quite a day. We walk into a classroom with all the fifth graders. The children are absolutely terrified at the prospect of getting shots. Some start crying at the sight of the injections. Some huddle into a corner. Some run off to another classroom; one boy escapes to his home and

is brought back by his mother, kicking and screaming. When asked, some say they haven't eaten, likely in the hope that this will protect them, only to be carted away for a meal and back for their shots.

The task of managing these children falls mostly to Jaspreet and the younger of the two nurses. They cajole, grab, placate, and every now and then threaten the children to get their work done. Jaspreet keeps up a constant monologue, "you're such a smart child, you know it's nothing, it doesn't hurt, now look away, look at your friends, tell me your name, tell me your roll number, okay it's done, it's over, now don't cry like a girl, I don't want to see those tears spill, just blink them back!" Jaspreet reminds the nurses to give out paracetamol tablets to the children, and they do.

For the first graders, a different strategy is adopted. The nurses sit in an empty classroom, and Jaspreet brings the children to them one by one, so the children will not get alarmed and become unmanageable. Jaspreet walks in with each child, physically lifting her to make her lay on a table face down, while one of the nurses injects her on the bottom. Again, Jaspreet keeps talking to the children, trying to both distract and comfort them.

When we are finished with the primary school, Jaspreet gathers the used syringes and their plastic wrappings, while the nurses complete their written records. We now move to the high school building on the other side of the compound. We meet the principal, and then wait in a lab room for the ongoing class period to be over. The four of us chat. The conversation is light and easy. At some point, I ask Jaspreet, "If there is a problem after they get their injections, do they come to you in the village?" Jaspreet nods, "Yes, they will come to me in the evening. After DPT it is hard to move your leg. Or if there is a fever, or a rash, they come to me. Then I explain to

them why it hurts and give them paracetamol." It makes sense now that she was reminding the nurses to hand out paracetamol.

The class period is over, and soon the grade ten girls come in and get their shots one by one. The grade ten boys take longer, so Jaspreet is sent to check on them. She comes back in laughing, "Such big hulks and they are just standing in the corridor, shoving each other forward, refusing to come in!" By the time we are done with the high school, it is past lunch. On our way out, we meet the principal again. He tells us the school is out of iron tablets. Jaspreet will have to collect and deliver a new stock for the school from the community health center. She will do it tomorrow she says. It will be her third visit to the school in three days. On the previous day, she had to deliver registers—where the school records iron, calcium etc.—from the health center to the school. *None of this work is incentivized.* As we walk out of the school compound towards the scooters, she whispers to me, "Can you see how much they make the ASHA run around?"

The ease with which Sukhdev told me in our first meeting that ASHAs who are making more money are more active, while not untrue, is only half the picture. It erases the way in which all ASHAs are in fact much more "active" than what the incentive format would have us believe. Incentives erase a chunk of the labor that ASHAs do because they exist only for a fraction of their work, not to mention that the amounts are remarkably low, and by being low reproduce a devaluation of the labor this work entails. It is not that Sukhdev is unfamiliar or unsympathetic when it comes to just how much works ASHAs do. But incentives normalize a narrow imagination of work. They become an easy shorthand, in this case concealing more than they reveal. The *formal* tasks for which ASHAs are remunerated comprise only the tip of the iceberg of labor ASHAs perform. ASHAs have to do vast amounts of *informal* labor to be able to scaffold up to these formal tasks. This informal labor, far from being incentivized, is not recognized as labor. It is invisible.

With Jaspreet, all kinds of unwanted work, like gathering used syringes and delivering school supplies, falls to her. When Jaspreet spends half her day getting schoolchildren vaccinated, she is expending energy in a highly engaged fashion; it is a visceral experience to be surrounded by crying children, to have look into their teary eyes and soothe their frazzled nerves, one by one by one. She is affectionate and stern in turn, and she has to be physically agile, lifting and grabbing them when need be. She shifts affect between the first graders, fifth graders, and tenth graders. After the nurses leave for the day, the after-effects of the injections will also be managed by Jaspreet. And yet, there is a plausible deniability to Jaspreet's labor. Managing children is so feminized in the popular imagination that there is no association that appears more natural than "women and children." And nowhere is this association more naturalized than in the ministry of health and family welfare, where "maternal and child health"—not paternal and child, or just maternal or just child health—is a central priority. In this imagination, how can children be work? It is what women do anyway.

INCENTIVES AS CONTROL

There is a crowd of fifty gathered in the community health center for the monthly meeting of ASHA supervisors in the rural block. ASHAs are not present, their monthly meeting is held separately. The room is largest one in the center, with wooden benches and plastic chairs arranged in theater style. The two side walls of the room are lined with windows with grills. On top of these windows, there are laminated poster-size photos of the health center staff at various events. The same faces appear, only the clothes they wear and the banners they pose with change from picture to picture. There is a life size cut-out of a somber-looking Captain Amarinder Singh, the current Chief Minister of Punjab, in the front of the room. Today the electricity is erratic. Muktsar is in

the Malwa belt of Punjab, bordering the state of Rajasthan. The climate here is arid, and even though India's monsoon is almost over there hasn't been a drop of rain. My thoughts drift to the Delhi showers. The women around me use their dupattas to fan themselves and wipe the sweat off their faces.

Shortly after we are served tea the meeting begins. Amarjot sir takes to the podium. He is senior staff at this health center, with an impassive face and a gentle manner. Two more staff members walk in and sit on the table by the podium. The room is filled with the sound of shuffling chairs as we all quickly half-stand in greeting. The microphone is not working. But Amarjot sir is loud and tall, and commands the room with ease. He announces the agenda for the meeting, and gets right into it. He reminds the room about all the reports that are due: ORS (Oral Rehydration Solution) reports from ASHAs about the number of packets handed out for diarrhea control, deworming day reports in the formats already distributed, etc.

Next, he brings up a recurring problem: the gap in vaccinations. "If coverage for the 1st TT (tetanus toxoid) injection is 100% then why is it 90% for 2nd TT?" he asks. There is some discussion around this, but nothing conclusive emerges. He moves on to the gap in JSY payments. Janani Suraksha Yojana (JSY), or Mother Protection Scheme, is a cash-transfer program for new mothers who give birth in hospitals. It is meant to encourage institutional deliveries. Here, it seems women who deliver in the rural block are not being paid the cash incentive due to them. Amarjot sir tells the nurses, "You take it in writing from patients if they don't want the payment."

But there is another issue. Women must have bank accounts and Aadhaar[7] (national ID) cards in order to receive the JSY incentive. Now there is discussion about how easy or difficult it is for women to get Aadhaar cards. It seems that a lot of women who are eligible for JSY have the

[7] A new form of national biometric identification introduced by the government, and controversial for data protection concerns and for significant gaps in population coverage.

address of their natal homes on their Aadhaar cards, which they must change to the address of their marital homes before they can be paid. The chatter in the room gets louder, and Amarjot sir asks everyone to be silent so he can proceed.

He picks up pace. “Collect school health demand, submit your cancer reports,” he announces looking down at his notes. For the next agenda item, he pauses and takes off his reading glasses to look up at the room. “The ASHA monthly report must be matched against that of the ASHA facilitator, nurse supervisor, and LHV. Also, don’t just issue the VHSNC[8] money to ASHAs. Check that a copy of the meeting agenda—signed by all members—is attached.”

Now Amarjot sir turns to the man and woman sitting on the table besides the podium. They are the statistician and the accountant for this block. He asks, “Any message from you?” The woman rises, and exchanges spots with Amarjot sir. She announces that one of the ASHA incentives is to be discontinued. It is the incentive ASHAs get for bringing in anemic pregnant women for iron IV. “I am not sure about this month, but from next month this incentive will be stopped.” This announcement is met with a loud murmur from the room. Immediately she holds up one hand for silence, “Please! Listen, I cannot do anything about this, I am just letting you know so when the payment doesn’t come, your ASHAs don’t form long lines outside my office to ask about it. The work still has to happen the same way, but the incentive will be stopped.”

She swiftly moves on to the next topic: the payment gap for JSY patients that Amarjot sir brought up earlier. She tells the room how to fix this gap, “You have to make sure that you take down all patient details, don’t leave any of the columns on the form empty or it becomes very difficult for us to make the payments. And take things in writing from patients. If the patient says, ‘I don’t have an Aadhaar card,’ or ‘I don’t want to run around to get this work done,’ then take it

[8] Village Health Sanitation Nutrition Committee: ASHAs are paid an incentive for attending these meetings

in writing. Then at least we will be able to explain the gap. Also, you tell the ASHAs, we will stop your JSY payment if you don't close this gap. You tell the ASHAs this for one month and see the difference. Look, you are the department. You have to make it run. You have to get strict."

She announces the names of sub-centers that have filed incorrect paperwork for JSY payments, imploring "Please check properly before you submit!" She has to raise her voice because the room is breaking up. Some people get up to leave, others come forward to speak to the staff, crowding around the table and the podium in little clusters.

In many ways, this meeting epitomizes the problematic character of the incentive payment format. When the accountant informs the room that the ASHA incentive for iron IV has been stopped, she does not have an explanation for it. But she announces that ASHAs are not to bother her by queueing up outside her office, and that incentive or not, the work of bringing in anemic pregnant women to be administered iron must happen as before. Even when incentives are removed, the work of ASHAs does not reduce. By expecting ASHAs to work with as much dedication, irrespective of incentive, the health department casts an image of an idealized, altruistic worker. This image is unrealistic, but when it is *unrealized*, the blame falls to ASHAs. ASHAs are just as easily represented as being too money-minded, as running after incentives. All employees work for money, among other motivations. But the incentive payment format casts ASHAs as somehow uniquely chasing money to the detriment of all other motivations. Many ASHAs told me in their interviews that they were frustrated by how the hospital staff spoke to them; 'you're back already, you're always here, we know you keep bringing cases because you get incentives.'

Incentives also function as a lever through which the health department can exert control over ASHAs. By withholding or threatening to withhold incentives, the department can arm-twist ASHAs into doing work that is outside their purview. This is evident from the accountant's

solution to the problem of the JSY payment gap. While the number of institutional deliveries is high in Muktsar, the number of cash transfers issued to mothers under the JSY scheme, which should be as high, lags behind. This gap is a problem for the health department. The accountant suggests that nurses withhold the incentive ASHAs get for bringing pregnant women to the hospital for delivery if the patient does not receive JSY. The ASHA incentive is paid to ASHAs for persuading the woman, usually after nine months of engagement and care, to deliver in the government hospital. The accountant implies that it does not matter that the work for which this incentive is given has been done, rather, she suggests the nurses use their ability to withhold payment to get ASHAs to do the additional and uncompensated work of ensuring JSY payouts to mothers. Never mind that the reason for the JSY gap could be unrelated to ASHAs, or outside their influence.

Telling a roomful of supervisors, "look, you are the department, you have to make it run, you have to get strict" implies that ASHAs are *not* the department. They are, rather, the object of the room's action, the ones with whom the room should get strict. This attests to the liminal status ASHAs have been given by the government, one that is located within the health department but also makes them outsiders to the department in many ways.

The next time I meet with Sukhdev, I ask him why incentives are paid unevenly. He explains that ASHA incentives are made up of activities that are routine, activities that fall under other verticals in the same department such as tuberculosis and leprosy interventions, and activities that are one-time campaigns, including de-worming and diarrhea control for children. Routine payments are not usually delayed, but the others can be because of systemic reasons. He pauses to reconsider, "Even if there are delays (he raises his eyebrows emphatically, as though to

indicate how rare this is) at the most the delay is a few months here and there, if the funds have not been coming. There is no other issue."

This sounds like an issue to me, but I temper my instinct to argue with him. Instead, I ask about ASHAs' JSY payments being withheld. He explains in his usual patient manner: "We give the payment eventually, but yes we sometimes put it on hold to put pressure on the ASHA for JSY uptake. Everyone from the SMOs to the civil surgeon is under pressure from above. They have to answer for the discrepancy between the number of institutional deliveries, which is high, and the JSY payments to mothers, which is low. So, they pass on the pressure. But this is not a big deal. It happens to us too. Sometimes the civil surgeon will say to me, I will withhold your salary till you turn in such-and-such report."

I am surprised. "They do this to the National Health Mission staff?!," I ask incredulously. "Yes," says Sukhdev, nodding. It dawns on me that the NHM staff is all contractual, that is, temporary. "Do they do this with other staff who are permanent," I ask. "No," says Sukhdev, grinning tightly. I widen my eyes at him. He simply shrugs.

Sukhdev's comment is suggestive on two counts. One, he admits that incentive payments can sometimes be delayed by a couple of months. But the way he frames this admission shows that he does not think this is an issue. Most women who work as ASHAs cannot hold down another job because of the hours and burden of the ASHA work. But the title of community health *volunteer* is grossly misleading; it suggests that the work of an ASHA is something women can do on their own time and on top of whatever else they do. Perhaps this is why the income from this work is not imagined as household or even living wage, but as petty cash, like honoraria or pocket money.

Two, Sukhdev, like the rest of the staff employed under the National Health Mission,[9] is a contractual and not permanent/tenured employee of the state. The NHM has been created as a parallel line within the Ministry of Health and Family Welfare. As a result, the health department now has two types of employees: a) regular with tenure, benefits, and significantly higher pay scales, like the civil surgeon Sukhdev reports to, and b) contractual with no tenure, fewer benefits, and lower pay scales, like the NHM staff. I am surprised by how normalized the forms of the pressure that Sukhdev describes are, coming "from above" and being passed down all the way to the ASHA. Sukhdev does not think it is a big deal to coerce work from employees by withholding payments because this happens to him too. He confirms that it is his contractual status that makes him vulnerable to this pressure in a way that permanent employees are not.

However, the position of ASHAs as *volunteers* is a qualitatively different vulnerability from that of NHM's contractual employees. Contractual employees of the NHM – both men and women, and the ASHAs – exclusively women, may both well be part of the same neoliberal model of austerity and efficiency. But ASHAs are a unique, explicitly gendered iteration of this model. As poor women serving other women through that quintessential women's health thematic: reproductive health, ASHAs both embody a gendered "neediness," and perform work that is devalued because of its association with women.

RELATIONS OF FEALTY

Nurse supervisors— Auxiliary Nurse Midwives or ANMs—are closest to ASHAs in rank and their immediate supervisors. Before the National Health Mission, there were fewer ANMs and

[9]Only the mission directors of the NHM (the highest authority in each state) are tenured. They are officers of the elite Indian civil services.

no ASHAs. Now, there are more nurses and ASHAs form a whole cadre of workers under them, so while the workload of the department has increased after the NHM, and though the nurses are no exception to this, they have also most benefitted from the appointment of ASHAs, who take a chunk of work off their hands.

I interview Jaspreet a few weeks after I attended the DPT and TT immunization in her village school. Here, she sheds light on the ASHA-nurse relationship.

> Me: Do ASHAs face problems with ANMs?
>
> J: ANM… well yes, there are problems, but I will never tell the ANM that I am facing a problem with her! (we both laugh) Even when I am very upset with her, I will say, I am so happy with you. I simply cannot. Because she files my monthly report. If I say anything, she will strike off my incentives. She will come up with something- 'there is a problem here', 'the date is different there.' The 2000 I am getting now will not even come to 1500.
>
> Me: But some ASHAs do fight with their ANMs…
>
> J: There are many ASHAs who have fights with their ANMs. When the ANM gets after you over and over again, some like me will say, never mind her, I have to raise my kids. Some others say, I have to raise my kids yes, but not like this! I don't want to take this crap. If I have done my work, why should I listen to her crap?
>
> Me: So what happens when they fight? What comes of it?
>
> J: Every time an ASHA fights with an ANM, ultimately it is the ASHA who has to give in. Never the ANM. I have made up my mind about this. I will never fight with my ANM. Because if I do, I will first get told off by her. Then I will get told off by the SMO, the civil surgeon, by everyone. All the ASHAs who fight, they have to finally eat crow. Even if the ANM is at fault, it is the ASHA who will lose.
>
> Me: Why does that happen you think?
>
> J: This happens because… See, if the ASHA were salaried like the ANM, if we marked attendance like the ANM, then maybe the department would respect us, the civil surgeon would respect us. They don't consider us their equals, they don't consider us a part of health department, like them. They think we are the lowest… the smallest of small fry. You know? No one says to us, 'come, come, have a seat.' We do our work standing up. *We* greet *them* with *namastes*. We ask, 'what can we do for you.' They think if someone is salaried, that means they are superior. If someone is not salaried, they are nothing. *They don't respect us because we are not paid* (emphasis mine). They think ASHAs have a duty, a free duty.

> Every time we bring up our payment we are told, your work is service, only service. Yes, we are here to do service, but what about our service towards our children? With 2000 a month, I can't give them two square meals. Then they say, you focus on the work, the money will follow! I have been doing this work for ten years now, I don't see any money following! The money never follows me! (Laughs).

Jaspreet brings to the surface the imbalance in the ASHA-ANM relationship. Jaspreet is unusually frank about this dynamic. Most ASHAs I interview, in response to this question ('do ASHAs face problems with ANMs') will deny there are any problems and launch into high praise for their ANMs. If pressed, they will say they have seen *other* ASHAs have problems with *other* ANMs, usually to do with being paid less than their due. Jaspreet describes ASHAs' struggle to preserve their dignity through their "neediness," and to be paid for their "service." She suggests ANMs always win against ASHAs because staff close ranks, and ASHAs are on the outside of this occupational solidarity.

Notably, Jaspreet believes ASHAs are not respected because they are not paid a salary. In her experience, the status of ASHAs as incentivized volunteers *legitimizes* their mistreatment by staff. In creating their post as it did, the state has marked ASHAs as less-than-equal. Staff simply follows this brief in treating ASHAs as inferior in status.

Jaspreet also shores up the moral force of motherhood, the most salient of women's claims to public life, to frame material demands of the state. She calls attention to her service to her children—her struggle to provide—that brought her to this role in the first place. In this way, she challenges the discourse of altruism used to deny ASHAs fair and timely pay, as well as the disingenuity of the response staff commonly give her—no, she insists, the money does not just follow.

I do not want to give the impression that nurses, or ANMs, only give ASHAs a hard time. An ASHA's nurse supervisor can also be her biggest advocate. Simran is a 50-year-old ASHA

from the city. Everyone speaks highly of her work. Simran has the aspect of a kind matriarch; each time we have crossed paths, she has been warm. She has a broad, easy smile with a few missing teeth. The ASHA on record for Simran's area is actually her daughter-in-law, but Simran works in her place. This arrangement is unusual, but it has her nurse's blessing.

Simran lives with her husband, two sons, two daughters-in-law, and five grandchildren. Her husband and sons spend all their earnings on drugs. Simran taught Punjabi in a local school for 24 years. This is where she became friendly with her nurse. The nurse would come to the school to administer vaccines, and Simran would help out. When urban ASHAs began to be appointed in 2015, the nurse suggested that Simran apply. Simran got her daughters-in-law to apply, and they were both appointed. But soon the pediatrician in the civil hospital who has additional charge of urban ASHAs, Dr. Suraj, objected citing a rule that no more than one ASHA can be appointed from one household. "My older son drinks a lot, and is a suspicious person, so we decided that my older daughter-in-law would recuse herself," explained Simran. The younger daughter-in-law stayed on. But she was studying for her BA then, and has a newborn now, so Simran works in place of her.

> Even now, Dr. Suraj says 'your daughter-in-law should come for work.' He kicked me out you know. I sat at home for two months. I was under so much stress. My daughter-in-law, in the seventh month of her pregnancy, started to come for work. My nurse was on maternity leave at the time. As soon as she got back, she went and fought with Dr. Suraj. She took me with her. She said, 'doctor sahib, this aunty WILL work with me'. I had lost my certificates you see, that is why I couldn't be appointed under my own name. But I know the work, I have done it from the very beginning.

Simran's daughter-in-law now tutors schoolchildren from their home. These are children who used to attend Simran's local school but dropped out to enroll in distance learning. They used to be taught by Simran. "She has taken over my work, I have taken over hers, and our family manages well now."

Simran has crafted something delicate. With her nurse firmly behind her, she has worked the informality of the ASHA role to her advantage. I suspect, though, that this takes constant and considerable people management. Her 'appointment' is precarious. It must drive her to work doubly hard. I pick up on some of her anxiety. By telling me she could not be appointed because she lost her certificates, she wants to appear driven by circumstances rather than calculation. And by telling me she has done this work from the "very beginning," she wants me to see her as imminently suited to the role. It feels like she is making a case to me, like she is arguing with the ghost of Dr. Suraj.

AREA FIGHTS

Then there is the matter of ASHAs fighting with each other over patients. Here too, nurses matter very much to ASHAs. They play the role of adjudicators, and exercise considerable discretion.

Technically, one ASHA is appointed for around 1000 people in a village. Most villages are more populated than that, so there may be two or three ASHAs per village. For example, in my interview sample, the population serviced by one rural ASHA was 1275 on average, and by urban ASHAs a much higher 2860 on average. With the populations under their charge, ASHAs can get territorial. If an ASHA "steals" a patient from another ASHA's area, this can create conflict. One of my earliest interviewees pointed this out to me. "If you really want to know about all our experiences, good and bad, you should ask about fights over area," she suggested. I then added a question to my interview schedule about this ('Do you face any problems with other ASHAs over your area?').

Since ASHAs earn incentives per case, the greater the population under an ASHA, the greater her opportunities to earn. ASHAs are also required to conduct household-level surveys for the population under them. Once an ASHA establishes herself in her area, builds rapport with the families that live there, and creates registers for these households, she is loath to give it all up to a new ASHA, even if the population of the village grows.

Many ASHAs explain this to me in their interviews. This quote from Manmeet, an urban ASHA, is a good example:

> Sometimes you have only one delivery case in a month. If someone else takes that case away from you, of course there will be a fight. For nine months I have looked after a pregnant woman, visited her, everything. It hurts. I had this case, where I brought a pregnant woman to the hospital and stayed with her all day. I went home in the evening to check on my son. And during that time, she gave birth and another ASHA got her name written on the case slip. My ANM made her give the case back to me.

The area in their charge is not solely a source of conflict for ASHAs. ASHAs also cooperate, much more than not. Many told me they get along well with the other ASHAs from their village/area, and that they help each other out. If one is unavailable, the other will step in for her patient, and they will find a way to divide the incentives between them. Many said that they especially collaborate on community-facing tasks. For instance, they prefer not to visit households alone, but in company. They find it easier to do surveys in a team, with one ASHA doing the writing and the other the talking.

But competition for patients can strain even the best of relationships, as in the case of Sheenu, who holds Gagandeep in high regard. Not only because Gagandeep is older in age and much more experienced as an ASHA, but also because Gagandeep has married into the neighborhood where Sheenu grew up, which makes them like extended kin. On Sheenu's daughter's last birthday, Gagandeep and her husband were like godparents, cutting the birthday cake with Sheenu's daughter before a cheering, photo-snapping crowd of guests. Things go awry

between them during the run up to a vasectomy camp in the civil hospital. There is pressure on staff to bring men in for vasectomies, so the camp can be touted as a success. ASHAs are especially vulnerable to this pressure; they have been told that they will not get their incentive for maintaining registers— INR 1500 a month – for the next six months if they don't bring in at least one vasectomy case each. The register incentive has just recently been increased, as part of Prime Minister Modi's Diwali, or Hindu new year, gift to ASHAs.

Vasectomy uptake is notoriously hard. ASHAs tell me they find it incredibly awkward and inappropriate to discuss vasectomies with men. Moreover, the association of virility with masculinity makes it near impossible that men will be persuaded to take on any "family planning" responsibilities, when they could so easily have their wives undergo tubectomies instead. Even though there is a Rs. 200 (USD 3) ASHA incentive per vasectomy, many will not succeed in recruiting anyone.

Gagandeep finds out that the one case Sheenu has managed to bring in for this camp is from Gagandeep's area. This infuriates Gagandeep. She had said to Sheenu, if you need a case let me know. But Sheenu did not inform her. When Gagandeep confronts Sheenu, I am present. Sheenu defends herself: "I gave money to this guy who is my mother's neighbor, asking him to bring me a case. But he decided to come himself. Gagandeep is not swayed. You should have told me. I feel so hurt because I didn't expect this from you. But only people closest to us can hurt us with their betrayal." Sheenu says, "if you think it is my fault, I will say sorry." Gagandeep waves her off and walks away.

Now Sheenu needs to blow off some steam. We get *chai*. She tells me she thinks Gagandeep is overreacting. "Why is she going on and on! I had to act to save my incentive. The loss is mine really. This guy, his incentive for getting a vasectomy is 1100 (USD 16), but he doesn't

understand that *sarkari* (government) money is slow to come. He has been turning up at my mother's, demanding money for his ration! And my mother has had to pay!*"*

The next day, I am at the postpartum unit of the civil hospital, where everyone is feeling the heat to bring in vasectomy cases. The nurses and their male counterparts— male multipurpose health workers— tell me they have been warned that one month's salary will be withheld if they fail to bring in any cases. These staff members are all either contractual or on probation. I ask the LHV: "Who is putting this pressure, can they actually withhold salaries?" She looks at me like she usually does, with a mix of exasperation and amusement, and says: "There is pressure from the top. All like this (holds her hand to her ear like a phone, to indicate verbal), nothing in writing. Anju Gupta has said for ASHAs, cut their family planning incentive. It is a way of getting work done!" Anju Gupta is the District Family Planning Officer. The incentive she is referring to is for the maintenance of one of the ASHA registers.

On my way out, I run into Gagandeep. She wants to talk about her outburst from the previous day. "What Sheenu did damages my area for me. She gave 500 (USD 7) to that guy! I don't bribe my patients to come with me. Am I supposed to pay out of my own pocket to do my work? Where is the sense in that?" I agree. I add tentatively that Sheenu was afraid her monthly payments would be cut. But this only makes Gagandeep angrier. "How can they cut our money? By that logic everyone's salaries should be deducted. Even the ANMs, the LHV. If people don't agree to get vasectomies, how can anyone force them to?" She explains to me that the incentive payment system means that an ASHA only gets paid for the tasks she does. If an ASHA does not bring in a vasectomy case, then she will not get the vasectomy incentive. Her superiors cannot just deduct another incentive, for something she has done, because she didn't bring in a vasectomy

case. “But a lot of these new ASHAs don’t understand that. They are easily frightened. And that becomes a problem for all of us.”

Gagandeep is technically right. But there is enough wiggle room in technicality to completely undercut it. I see this unfurl over the next few weeks. Many ASHAs do lose part of their Rs. 1500 register incentive. In response, the ASHA union puts pressure on Sukhdev to set this payment issue straight. So, he pays a visit to the postpartum unit. But the LHV is a formidable opponent. She dodges the matter of the vasectomy camp, and insists the ASHAs who saw deductions were not maintaining their registers correctly. She pulls out a couple of registers to demonstrate this. She begins to nitpick: “look this is wrong, where is the column for __, look these entries are not updated.”

There is much arguing, but ultimately everyone is exhausted by the circuitous discussions. They end the meeting by agreeing that incentives cannot be cut for not bringing in vasectomy cases. And that ASHAs must maintain their registers properly. This is the ‘resolution’. What does it mean? That the matter ends with the vasectomy camp, no more incentive deductions. But for whoever saw a payment deduction in the last month, tough luck.

Despite Sukhdev’s efforts, he does not win. The LHV succeeds in shifting the goalpost. The LHV is only a handmaiden to a dysfunctional health system, one that sets an untenable goal, and saddles the staff at the bottom of the food chain with the responsibility for its attainment. ASHAs are the only ones who absorb the punishment for not meeting the set “target”—this *is* a target even though the health system has wised up to not calling it that. Because the incentive system makes room for such (in)discretions. Incentivized pay is the *constitutive modality* of ASHAs’ work. It sets them apart from all other members of the health department. It is not just form, that is, it is not just one way to structure wages, like a salary is. It is also content, like loaded

dice. It renders invisible vast amounts of ASHAs' labor, makes them easy to manipulate and overwork, and ultimately lowers their wages. Sukhdev had suggested to me when I first met him that the role of an ASHA can benefit needy women. He should have added, it can also compound their neediness.

Chapter 2: Motivational labor

> In the village I have to greet everybody, even the people I don't like. To win people's trust, you have to do a lot. If I don't do it, women won't come for check-ups, get vaccinations, when I need them to. They won't take their medicines. We have not been ordered to spend all this time with people. But how can I not? When I enter someone's house, where is the daughter-in-law? In the kitchen. It is the mother-in-law who opens the door, so I have to talk to her. I have to tell her why I am there. She will say, my daughter-in-law is not taking her medicines, she just lies around all day and does no work, blah blah. I have to listen to her say her piece. Only after this will she summon the daughter-in-law, ask her to come out and listen to me, send her with me for her tests. See I have to take both sides. But I can't tell one what the other has said. I have to maintain my relationship with both.
>
> -Interview excerpt, Jaspreet, rural ASHA

"During home visits, do ASHAs go through the postnatal checklist like they are supposed to, or do they only gossip?" an accountant asks nurse supervisors in a monthly meeting in the rural block. I think about the casual way in which the question is asked. The idea that ASHAs "only gossip" is a common one among health department staff in my field. This idea sits alongside another dominant idea among health department staff about ASHAs, that what they do is service. Service is respectable. Gossip is not. Nonetheless, both ideas draw on the gendered notion that care and conversation come naturally to women, that they do it anyway, and that this is not real work.

Maybe because of my own propensity for it, I take the idea of gossip seriously. In this chapter, I trace the contours of what is routinely dismissed as gossip but what I call ASHAs' *motivational labor*. I begin by juxtaposing what the rural block accountant considers "only gossip," with what rural ASHA Jaspreet explains as a necessary entailment of her work: the building of intimate relations between ASHAs and the women in their communities. Under the National Health Mission, a key responsibility of ASHAs is to "mobilise the community and facilitate them in accessing health and health related services" (Ministry of Health and Family Welfare,

Government of India 2021). In the field I hear senior health department staff say to ASHAs all the time: "your job is to motivate patients." In their trainings, ASHAs do roleplay to learn and practice how they will motivate women. They are coached on what to say to promote governmental health services. They are asked to emphasize the benefits of the service—whether it is free of cost or incentivized, how it ensures the health of mother and child, and so on. The trainers go over different pitches to persuade stock 'types' in the field—the superstitious mother-in-law who is against vaccines, the busy husband who doesn't have the time to accompany his wife for a hospital visit. While this may be appropriate, I find the motivational labor ASHAs do far exceeds what is officially taught. In this chapter, I explore the foundation upon which ASHAs' motivational labor rests: the building and sustaining of relationships with women in their communities. Relationship building requires emotion management, time, and money from ASHAs. It also requires a very particular kind of skill: a deft combination of insider sociality and discretion. This is honed over time such that it becomes an instinctual part of the role of an ASHA. Motivational labor is indispensable for ASHAs. Without it, women do not "get behind" the ASHA, or use the health care services to which they are being directed.

"THE WORK OF AN ASHA IS NOTHING IF NOT CHATTING!" - SHEENU

I am able to observe the fine-grained quality of motivational labor when I visit Sheenu's area with her. It is 20th October 2018, and the day has been declared an official government holiday because of the events of the previous day. The 19th of October was the Hindu festival of Dussehra; revelers had gathered by the railway tracks in Amritsar district to watch the customary burning of an effigy, when a fast-moving train sliced through the crowd, killing sixty. The government of Punjab had announced a day of mourning. I expected to stay home. But around 8.30 am, Sheenu

called to tell me she will be going to work. At this point, Sheenu and I are hanging out every other day. She collects me on her two-wheeler. As we wind our way through the narrow streets, she tells me, turning her head so I can hear her, "Just see, they will be all fired up to yell at me!" Sheenu has not visited her area in the last ten days. It was the Hindu festival of Dussehra yesterday, which is preceded by nine days dedicated to different Hindu goddesses. Devotees will fast during this period, and Sheenu is a particularly fierce devotee of 'Mata Rani,' the mother goddess.

We spend the next four hours in Sheenu's area, getting on and off the two-wheeler outside various homes. Sheenu is an outgoing and friendly person, but I am struck by the emotional range in her interactions that morning. The first home we stop at is for a postnatal visit. Sheenu chats up the woman's mother-in-law the whole time we are there, as she weighs the baby and asks after the health of the woman and her child. The mother-in-law is concerned that the daughter-in-law isn't producing enough breast milk. Sheenu reassures her that this is quite normal, and advises the daughter-in-law to drink more fluids. As we leave the house, she calls out in jest to the mother-in-law, "the fan is running in your other room! Looks like the electricity bill isn't high enough for you!"

In the next home, a couple is concerned that their infant son, a one-year-old, walks on his toes and not his feet. Sheenu furrows her brow, her face mirroring the anxiety on theirs. She asks, "have you consulted a pediatrician?" "Yes" says the father, "he told us there's nothing to worry about." Now Sheenu sheds her somber expression. "Then it must be fine," she exclaims.

But this issue gnaws at her after we leave the house. She stops, and goes through her phone. She remembers that her nurse supervisor's[1] son has the same problem. She calls her nurse, who confirms that she too has been told her son will outgrow it. Sheenu shares this message with the

[1] ANM, or Auxiliary Nurse Midwife: nurses who are direct supervisors to ASHAs.

couple we just visited, also WhatsApping a video of the nurse's son pottering about for good measure. When she is done, she looks up at me from her phone and says, "poor things, they must be worried that there's something wrong with his legs."

I note that Sheenu is consulted by the people in her area for a broad range of ailments, and not just for birth and vaccination. These people know Sheenu is not a doctor, but they see her as 'in the know'. They trust that she will have advice for them. And she usually does.

We walk into a neighboring home, and catch the family packing their bags and loading up a bike. They are going to attend a fair in another village. Two little girls are running around in frilly dresses, with make up on. Sheenu stops them and says, "show me how pretty you look! *Waah!*" A woman comes out to greet Sheenu warmly. Her daughter-in-law is due to deliver any day now. Sheenu asks after her. She is well, but the woman is worried about her daughter, who is sick. She says, "I want you to see these reports, Sukhpreet.[2] We don't know what to do. The doctor said there is infection, have her admitted, but we don't know what or why." The woman is clearly stressed. She hands a blood report to Sheenu, saying, "you tell me what to do." Sheenu looks at the report and has me look at it too. All it says is that the white blood cell count is high. Sheenu tells her, "we will have to have a doctor see this. You bring her to civil with all her reports. Only then can we be sure." Sheenu's advice is sound, but it does not bring much relief to the woman.

In one of the next homes we visit, we are greeted by a very pregnant woman. She is petite and looks like a young girl, so I am a little surprised to learn this is her fourth pregnancy. Sheenu tells her it is time for her check-up, so she must plan to come to the civil hospital with Sheenu one of these days. The woman tells Sheenu: "I need to ask you something." Instinctively, Sheenu leans in from the edge of the cot where they are both sitting. The woman continues: "You know I am

[2] Sheenu is a nickname. Her first name is Sukhpreet.

giving this child away. My other three deliveries were in the government hospital and I want this one to be there too. But the RMP[3] here told me, there will be problems with the birth certificate if you deliver in the government hospital. He wants to take me to a private hospital for delivery, so we can get around the birth certificate…"

Now Sheenu reacts aggressively. *"Arey,* no! If you want to give the child away, you should do it properly, with all the correct paperwork. Even in a private hospital, the birth certificate will be made in your name. This man is guiding you all wrong!" Sheenu warns her that she will end up paying much more if she goes private, and that the RMP will pocket a chunk of the money. To emphasize the point, she provides details about her own life. "You know, I was also given away to an aunt. In Gurgaon (a suburb of Delhi). But they returned me to my mother because I would get sick a lot. They had lost kids before, so they were superstitious too. Later, that family made so much money. If they want, they can help me out now. They can even buy me a house. But they don't do it. If my mother had had me adopted, with proper paperwork, I would have some legal rights. I have nothing. You need to think about your child. In the future, your child should not be left hanging. Get proper papers. Do the delivery in the government hospital. You don't have money to waste!"

To this the woman says, "I have kept 15000 (USD 200) in the bank for a rainy day." Sheenu's face softens into a smile. She says gently, "you get earrings made for yourself with that money. But if you still want to go to a private hospital, I can get you a cheaper deal." The RMP has quoted 10,000. Sheenu says, "I will get your delivery done in 7000." She adds with a laugh, "you can give me *badhai*[4] out of what you save." (Later she will say to me, "I have been running

[3] Registered Medical Practitioner: an informal class of local 'doctors' without medical degrees but usually with some education and variable training.
[4] A small sum of money intended to be a celebratory gift/reward.

after her for nine months, why should this RMP get her case. I will get her a discount of 3000, and make 1800 for myself.")

The woman is visibly pleased with this conversation. Her body has relaxed. She says to Sheenu, "you are right. I will use the government hospital. I had told mummy, I will talk to Sukhpreet. You talk to mummy too." Sheenu nods her agreement. The mother-in-law is home after 5 PM, so Sheenu will be back another day for this conversation.

At the next house, the daughter-in-law who Sheenu needs to check up on is not in, but we sit for a while anyway. The mother-in-law offers us *chai*—which we refuse politely—and launches into a tirade. Her son has not come home for two nights. He is visiting his wife, who is visiting her parents. The mother-in-law complains: "you know I do all the housework. We take such good care of her. She is in her room all day, speaking to her mother on the phone. She tells her mother everything, big and small, that happens here. She doesn't treat us like we are her own." Sheenu commiserates. She nods sympathetically and makes assenting noises: "This is wrong. You're spoiling her. But don't worry too much. She will settle in time. Whatever it is, everybody has to maintain these relationships." The mother-in-law is fidgety and distracted. I don't know if Sheenu's platitudes are finding their mark with her. But when we take our leave, she gives Sheenu a hug.

It is clear that Sheenu plays the role of counsel for many women in her area. In addition to discussing their pregnancies and ailments, they also share their troubles. Sheenu can't always help them out, but she lends an ear. This seems to have a reassuring effect on the women.

Sheenu drops by the neighboring home for a chat. The woman who receives us is warm, and summons her daughter to greet us. Sheenu asks her, "that Kiran, pregnant, from the next street, she is related to you right? I have told her so many times to come to the civil hospital for her tests.

She doesn't listen. And the last time, as I was leaving, her father-in-law said loudly, '7 gm hemoglobin is more than enough, what do these women know, they are just roaming the streets.' Is this any way to talk? It is so insulting!"

The woman is sympathetic. She advises Sheenu to let it go: "I know that family. They only go to the *dai*.[5] Just forget about them."

We go to another home for a postnatal visit. This baby is a boy who was born just a week ago to the younger of two daughters-in-law. The house is bustling. We join the mother-in-law, the elder daughter-in-law and her three little daughters, and a neighbor, who are all sitting around fussing about the new-born and his mother. Sheenu is done checking on the baby quite fast, but we stay a while to have *chai* and chat. Much of the conversation is about how to ensure you give birth to a male child. There is consensus that while every child is a gift from god, at least one should be a boy. They swap 'treatments': Sheenu is emphatic about hers, since she has seen it 'work': "Eat the flower of a coconut plant at 4 AM, after taking a shower, and ensure you come in contact with only men that day."

The conversation is on the whole easy and jovial. So, I am surprised when we walk out of the house and Sheenu cusses at them.

It seems that when the younger daughter-in-law went into labor last week, the family rang up Sheenu, asking her to accompany them to the government hospital. Sheenu is a single mother to two young kids. Because it was close to midnight, Sheenu asked the family to collect her from home. To this, the mother-in-law just hung up muttering with incredulity, "now we have to collect her too!" The family ended up going to a private hospital instead for the delivery. Sheenu tells me, "they should have just said they can't pick me up. I would have gone on my own scooty. I do it

[5] Traditional birth attendant in home deliveries.

when I have to. They didn't even ask once." Sheenu disgustedly shakes her head, belying the amicability of the home visit we just conducted.

There is a lot of surface acting involved in the work of an ASHA. Sheenu is not conflict-averse; with friends I see her speak her mind, even pick fights, all the time. But in her area, Sheenu has to suppress these instincts. She must be warm, understanding, and polite when she is trying to persuade patients, especially the recalcitrant ones. She tells me it is deeply frustrating, and a lot of work. With some patients she has to make many phone calls and many rounds of their homes, but she cannot afford to fight with them. Not only will she lose those patients, but she will get a bad name and lose potentially more patients.

As we continue with the morning's visits, I see more evidence of this. At one home, we dodge two buffaloes tied with a long rope in the courtyard, to climb up a flight of stairs leading to the terrace. A pregnant woman is doing the dishes. Sheenu asks her some questions, and requests her (for the fourth time, I learn later) to come to the civil hospital for tests. The woman is not impolite, but she is less than interested. Sheenu asks her why she doesn't answer her calls ("it is my husband's phone, and he is away at work"). Sheenu offers to write down her number, the woman hands her a scrap of paper ("I don't know where I've kept the diary"). "Never mind," Sheenu says sweetly, "you keep this number safely and call whenever you are ready for the tests."

Once outside, her manner changes. She tells me she is fed up with this one. She will tell her nurse supervisor to come with her the next time, so she can see how difficult this woman is. This will also be a form of insurance; if anything goes wrong with this case, the nurse will know how hard Sheenu tried and will not haul her over the coals for it.

The next visit is a postnatal checkup that we wrap up quickly. The family is warm. When we enter the house, a little girl runs up to us to say, "all the kids are away playing!" Sheenu retorts,

"and what are you, a grandmother??" Everyone laughs. Sheenu is very friendly here; she smiles a lot and plays with the baby. When we leave, she tells me, "they seem so nice, right?" "Yes yes," I say nodding. "Well, they are not. They complained about me to the Senior Medical Officer. You know that government scheme, where the mother receives 6000 for the first child? They thought I had pocketed that money from their first child. The SMO explained to them that their first, the daughter, was born before the scheme was announced, so she was ineligible. I felt really bad about that."

After a morning of tailing Sheenu and absorbing the many exchanges between her and various families, I am exhausted. It becomes clear to me that what ASHAs have to do on a daily basis goes well beyond the job description. Shashi, an upper-caste rural ASHA was able to put this into words for me. She explains what her interactions involve:

> S: In this work, some listen, some don't. The ones who don't listen, you have to explain to them three, four times. You have to expend so much mental energy. Women will hear me out, but not all of them follow what I say. Like when they started giving out sanitary pads, some families would say, we use a cotton cloth, what is this new nonsense you've started? I would say, *bibi*, those have germs, this is better. They would say, germs may bother you, they don't bother us! (laughs) It took time and a lot of explaining, but people began to use pads.
>
> Me: To be able to complete your work, is there anything else you have to do for these women?
>
> S: Everything we can. There is one's duty, of course, and then there are all these other things one has to say, to explain to people. You have to share in people's joys and sorrows. Someone has problems with the mother-in-law, someone with the daughter-in-law. I speak to them as much as I can, without overstepping. It is about maintaining relationships, taking people along. For instance, I have to explain to the mother-in-law very nicely, *bibi* your time was different. Our daughters-in-law go with us to the hospital nowadays, even though we delivered babies at home. Your diet was very good. You used to have *desi ghee* (clarified butter). There was no spray in the fields then. It's not like that now. You were hardy. Kids these days are not. That is why they need to go to the hospital.
>
> Me: What challenges do you face?

> S: There are many challenges one has to overcome. Some families just don't agree. They say, we have had all our kids at home, we will not go to the hospital, what is it to you? We have to explain over and over again: everything will be free, you will get money, your child will survive, the mother will survive. You have nothing to lose. You just have to get there. At least come and have a look at the hospital once. Some people don't have any means of transport. Then we organize an ambulance for them. The long and short of it is, ASHAs have to plead with people for every little thing. This one time, I took a bowl of wheat from my house to this woman's and made *rotis* for her there. She was hungry, and they had nothing. The husband was on drugs. Then I told him off, 'these are your children, can't you earn for them? She is pregnant, you should be taking care of her. Is this woman only a child-bearing machine to you?' These are challenges, right.

Persuasion takes patience, perseverance, and meeting people where they are at. Shashi has to go over every aspect of using a government hospital. She has to make repeated visits and pleas till she finds her mark. She describes how she talks to the *bibis* (older women), flattering them as she makes a gentle push for new practices. Shashi is clear that there is one's "duty" (the job itself), and then there are all these other things—commiserating, counseling, in one case, even cooking.

The skill that ASHAs develop on the job is not easy to observe because they make it seem so natural. But it is not natural. It is developed though time and familiarity with the community. It develops into comfort and discretion, guiding ASHAs about when and how to make a push, and when and how to hold back. I see this with Gagandeep. Gagandeep is a Mazhabi Sikh (SC) urban ASHA. She started off as a rural ASHA in 2010 in the neighboring block but switched to the city in 2015 when positions opened up for urban ASHAs. She is a successful ASHA on all counts: she is a high earner, well-liked, and has the manner of a wise, older woman. She is a person of few words, which lends gravitas to when she does speak.

I visit Gagandeep's home when there is an EPI (immunization day) in her area. The nurse supervisor uses Gagandeep's home as the venue where vaccinations are done because Gagandeep's home is centrally located. It has a courtyard where they open out two cots. The shanties around Gagandeep's home belong to migrants from the neighboring state of Rajasthan

who have been in Punjab for a generation or two. For Gagandeep this means some additional work keeping track of the daughters, many of whom are married in Rajasthan but spend a lot of time with their natal families here in Muktsar. When these women get pregnant, Gagandeep must make sure they don't fall behind or double up on their vaccinations.

I accompany Gagandeep as she makes a round of these shanties. She is asking women who are due to go to her house and get their vaccinations from the nurse. It is evident that Gagandeep is well-established here. The children playing outside come and touch her feet as a mark of respect, others call out "*sasriakal"* in greeting. Several women ask her if she would like to step in for a cup of *chai*, or for a meal. They speak to her with ease and warmth. One woman asks Gagandeep to confirm that the medicine she is taking is the right one, another shows her a contraption that is supposed to help her conceive. I ask Gagandeep, "do you find it easy to work here?" She replies that it is not always easy. "People here are superstitious. Things get stuck in their heads, and it's hard to shake that. Like, someone gets sick right after she gets an injection, so she will say the injection made me sick. This woman had a miscarriage, and she blamed it on the ultrasound she got at the civil hospital. So, with her next pregnancy, she just refused to get a scan. I used to find it very difficult in the beginning. Now they listen to me."

"What helped, you think?" I ask. "Well, for one, time. I've been doing this for a while now. But also, when a case goes well, like a woman delivers normally in civil and she and the baby are healthy, then she will tell everyone in her lane. The word spreads, and soon everyone follows suit. The main thing is, these people don't trust the hospital. And they don't trust the doctors. They insist that the ASHA comes along and is with them through every step of the way. They don't want to let go of us."

Gagandeep is summoned into a house by a young woman. When we step into the small courtyard past the gate, there are three other women lying around on cots, and at least eight children. They all seem to be enjoying a lazy morning, sunning themselves. The young woman eagerly tells Gagandeep she wants a tubectomy. “Can I do it today?” Gagandeep begins to give her details of when and how the tubectomy will happen at the civil hospital, when a man walks out from one of the rooms and interrupts Gagandeep: he protests softly “my mother has just injured herself....” He does not need to complete what he is saying. Gagandeep immediately switches tracks. With a wave of her hand, she says to the young woman, “You take care of your mother-in-law first! Your operation can happen later.” Everyone is half smiling as we leave, including the young woman whose efforts at escaping mother-in-law duty seem to have been thwarted.

Gagandeep’s spontaneity, tact, and lightness in this situation pretty much sum up how ASHAs successfully maneuver social relations in their communities. Over the years, she has developed a position of relative power for herself in her area. To get here, she has had to account for people’s beliefs and meet their needs. Today, she is careful about how she wields her power. As we see with the tubectomy, she does not chase after outcomes alone, but is mindful about preserving the access she has to households.

Succeeding at the role of an ASHA also takes forbearance. One of the office bearers of the ASHA union confirms this for me when she puts it plainly during her interview:

> Some ASHAs know how to connect with people, how to talk to them—call them *veerji* (respectful term for brother), *behnji* (sister), how to tolerate things. A patient might swear at you one time, you have to take it. You have to say, never mind they were angry. If you say, ‘I am an ASHA, why should I let anyone abuse me?’ then nobody will go with you. It is difficult, but this is the work of motivation.

The particularities of the ASHA role—bringing poor and marginalized communities into government hospitals—presents unique barriers. In order to persuade patients, ASHAs have to practically rebrand the government. This can take a lot of extra work, as Navdeep explains:

> It is very difficult to persuade people from the village. They say, the quality of care is very poor in government hospitals, no one bothers about us there. They've had bad experiences earlier. It could be one doctor, but it gets into people's heads that this is how all government people are, how all government facilities are. The entire staff gets a bad name. So it's a lot of work. When I go to someone's house, I have to first talk to the main member. If I talk to the pregnant woman, she will say, you ask so-and-so first. So whoever is the head of the house, I have to explain everything to them. All services, all facilities. Sometimes when people don't listen, then we have to go to someone in the village whom they do listen to, someone they trust, like the *sarpanch* (head of local government), the *anganwadi* (childcare center worker), the nurse. We take them along so they will listen to them.

Once the patient is persuaded, ASHAs have to manage the patient's expectations. They will tell patients to come to the hospital early and be prepared to spend half the day there. But mostly, ASHAs end up absorbing the delays on the part of the health system. For instance, Janki, an elderly urban ASHA, tells her patients they just have to give their samples at the hospital and leave; Janki collects and delivers their reports. Janki explains:

> I will visit a family again and again and again to motivate them. I chew their brains (laughs). When a couple is newly married, I am eagerly awaiting their pregnancy! I will keep asking every month. Some laugh it off, some get mad (laughs). If there is only a husband and a wife, I will tell the husband, you go for *dehadi* (day labor), I will take her to the hospital. For very poor families, we pay out of our pocket. I pay for their rickshaw, their *chai*. Once my son donated blood for a patient. Once I paid Rs. 500 because someone was referred but couldn't afford passage to Faridkot (the civil hospital in the adjoining district).

Janki's experience was a common one. ASHAs pay out of pocket for some patients' rickshaw fare. For patients who need blood, ASHAs help organize donors. In the hospital, ASHAs act like guides, padding patients from long waiting periods and from being tossed around room to room.

Harjot has been an urban ASHA for only four months when I interview her, but she already understands and performs motivational labor. When I ask her, do the women you bring to the hospital like it here, she says it depends:

> If they meet the doctor and get done quickly, then its fine. If they come in the morning and are still sitting around at 5 PM, then they vow never to return to the civil hospital. We have to really motivate them. I tell them, you are getting free tests that would cost you 5000 if you went to private. I do as much as possible for them. I get their slips made, get the tests written by the doctor, give it in the lab, after 3 PM collect the reports from the lab—it is never ready before 4 these days. We do all this because patients get fed up.

ASHAs improvise constantly on their role. Their work is akin to developing an entrepreneurial skill, because they are creating a demand for services where there was none. I see this with Kamla the very first time I accompany her to her area. Kamla drops off a birth certificate at one of the homes. At the gate, she tells me she had promised this family she would deliver the birth certificate of their newborn child to their home, which she did. But the thin single sheet tore in her bag, so she is now back with another. As she hands the birth certificate over to the mother, for the second time, she points to the hologram sticker at the top: "Without this, it is useless. Get it laminated so the sticker doesn't fall off." I know that ASHAs are not required to deliver birth certificates to people's homes. Early in my fieldwork, I assumed Kamla was being especially nice and hardworking, which she is. But I realized with time that several ASHAs deliver birth certificates to people's doorsteps. They do it as a gesture of care.

Building relationships takes mental, emotional, and physical work. It relies on both deep and surface acting (Hochschild 1983). It consumes resources of time and money. And it increases the burden of work on ASHAs. But ASHAs do it to create an effect: trust. As Alka, an urban ASHA, explains, "I speak with a lot of affection. I share stories about my family, and natal family, and ask about theirs because I want them to feel close to me. I commiserate because I want them

to feel like I am a well-wisher." ASHAs describe calibrating their conversations according to whom they speak. Harjot explains how she does it, "You have to make relationships. If someone is from the same *gotra* (clan) as me, I will call her *didi* (elder sister). If she is from a different gotra, I will tell her you are my *bhabhi* (sister-in-law)." The value of trust is difficult to understand in the abstract. It was once described to me in poignant terms by another ASHA Manmeet: "People say to me, you can take our daughter with you, unaccompanied, and it does not worry us. That is how much they trust me." In Punjab's villages where young women are highly surveilled—with natal families' anxieties around their sexuality serving to restrict their mobility—this is a big deal.

MOTIVATIONAL CAPITAL: CASTE DYNAMICS

The experience of motivational labor is not uniform for all ASHAs. ASHAs may have more or less of what I call *motivational capital*. Motivational capital is the capacity to convince a community, to persuade them to follow your advice for their health care needs. It is inversely related to motivational labor, that is, ASHAs with more motivational capital will have to do less motivational labor. Motivational capital may be related to experience. For example, ASHAs who have been in the role longer have the benefit of time and have made a name for themselves. They probably invested more motivational labor in their early days, but do not need to do as much now. On the other hand, ASHAs who are newly appointed have less motivational capital, and have to do more motivational labor, to persuade the population under their care.

I find that a significant determinant of motivational capital is caste. On 30th November 2018, I visit Guneet's village. Guneet is a Jat Sikh (General category/ upper caste) rural ASHA. She is a widow, and has been in this role since 2008. She is now 43, and lives with her two sons and her mother-in-law. She has studied till the tenth grade, and her self-reported monthly

household income is about Rs. 35000 (USD 500). Guneet is a stately looking woman. There is a softness about her. She has a polite, gentle manner when she speaks. Her skin glows with smoothness. Her clothes are pretty.

I reach Guneet's home at 9.30 AM. It is a large *pukka* (concrete) home in a gated compound. There is a lot of hustle-bustle already because of the construction work going on; they are building a new floor. The compound also has an *aate ki chakki*, a stand-alone room with a mechanized wheel that grinds grain into wheat flour. People from the village use this grinder for a small price. Opposite this dusty, noisy room is another stand-alone room, nicely tiled and sparkling clean. This is Guneet's RMP (Registered Medical Practitioner) office: she is one of the two RMPs in this village.

I have to wait for Guneet to finish speaking to two male visitors about some paperwork. The furniture is in disarray, and I sit in the only spot I can find, by her dressing table. Before we head off, she shows me three different creams she uses for her face. One is a fairness cream, the other is a cold cream, and the third is sunscreen.

Today Guneet is going house-to-house to conduct two surveys. One is a regular household survey register that ASHAs maintain, with details about household members like names, education, and contraceptive use. Because the central government has increased the incentive amount for routine activities—like maintaining this household register—the ASHAs have been told to update their records. Now ASHAs can expect their supervisors to conduct random register checks.

The second is the Non-Communicable Diseases survey. This is new. It is a list of questions ASHAs have to ask all household members above 30 for every house in their area. The questions are about exercise, smoking, drinking, blood pressure, etc. If a person scores above a certain

threshold, then they are determined to be at risk for non-communicable diseases like diabetes or cancer and are referred to the hospital for a check-up.

We walk down the lane from Guneet's house. The lane is cobblestoned and, in some parts, lined with potted flowers. It reminds me of Punjab's capital, Chandigarh, famed for its modernistic planning, cleanliness, and greenery. All the homes here belong to General category (upper caste) families. They are alike: large *pukka* houses in gated compounds. Guneet opens the gates and walks right in without a pause.

During these conversations, I notice Guneet has to often guess at people's ages. Women will say they don't know exactly how old they or their family members are. Sometimes they remember birth years. When Guneet does the NCD form, she doesn't go line by line, rather, she filters the questions and rolls many into one by asking simply, do you have any health problems? This is saving her time and effort, but she may be missing some things. I can't help but ask why she never asks women the question about whether they consume any intoxicants, only men. She says simply, "women don't do drugs-alcohol here, maybe in Delhi women do all this but not here." I am suitably silenced.

There is a lot of intimacy on display in these interactions. She asks an elderly couple if they have trouble sleeping, and the man starts telling her how stressed he has been about a new shop he has recently opened. In another house, we discuss a wedding that is taking place the same day in the village and who is invited, who is not. A frail and hunched old woman wants Guneet to help her resume her pension payments, so she explains how her other daughter-in-law came to kick her out of her house. At the house where we have tea, Guneet shudders as she tells our hostess about me, "she takes her coffee totally black, totally *phikki* (unsweetened)." They start discussing how much milk their respective households consume. The woman tells Guneet about her cow, tied a

little distance away from where we are sitting. Now that so-and-so doesn't live here anymore, the cow is for sale. Guneet makes inquiries. She might buy this cow.

Guneet's visits are sprinkled with casual but attentive observations. She comments on the paint on a side wall wearing off, on how well the new plants are doing. She asks when the front porch was cemented. She checks out the embroidery someone has been doing on small square of cloth. Only on one instance, I see her shrink. We are sitting in a neighbor's courtyard when a tall, older *sardar* (Sikh) man walks in, with a big shawl wrapped around his upper body, hands not visible. Guneet bows her head to say *sasriakal*. He asks after her, and before moving on, remarks, "your son was hired on my recommendation, he needs to focus on the work more." I learn later this man is her deceased father-in-law's younger brother. He used to be the village *sarpanch* (head).

When we are done and back at Guneet's, I ask her if she will be visiting any SC houses. "I have already done those," she remarks. I ask her if she faced any difficulties. "No no, none," she answers. She adds with a shrug, they do a lot of *zarda* (tobacco)!"

The ease with which Guneet conducts her home visits is brought home to me two days later. It is 2nd December 2018, and I am in another village, observing another rural ASHA, Navdeep, conduct the same two surveys. Navdeep is 31. She has been a rural ASHA since 2010. She is Bohria Sikh (SC).

On our rounds, I notice that Navdeep too, like all the other ASHAs I have seen, strides confidently into people's homes. If a gate is closed, she bangs on it and then throws it open without waiting for a response. In my interviews, many ASHAs complain that General category homes are big and gated, and they have to wait for a long time in the hot sun before anyone answers their

knocks. But Navdeep is an old hand, and her familiarity seems to save her time and trouble. The homes we visit that day are mostly General (Jat Sikh or Mahajan), and some BC (Mistry).

Navdeep laughs easily, and her eyes sparkle when she does. During home visits, she jokes and smiles a lot. She walks in to one home and deepens her voice to mockingly announce, "we are the police, we have come to put your names down and take you to jail!" In another home, Navdeep sweetly chides a woman who is also a tailor: "I can see my suit piece is still in the plastic bag I gave you and you told me you are almost done stitching it!" A little girl in pigtails pipes up "never believe my mother, she lies a lot!"

Before we turn into another lane, the last home we visit is especially big. It belongs to a Jat Sikh (upper caste) family. As always, Navdeep bangs on the gate briefly, before opening it and walking in. We cross the length of a rectangular field before coming to a concrete mansion at the other end. It is clear from the neat row of crops that the field is used for cultivation. I can see an old man sunning himself on a cot, half stretched. A dog's head sticks out from under the cot.

Two women step out and stand by the old man. As we get closer, the dog begins to snarl at us. Navdeep greets everyone with a quick *sasriakal*, to which the women respond but the man does not. I know Navdeep is terrified of dogs. One of the first remarks she made when we were introduced was that dogs are the bane of an ASHA's life. Now, she cannot stop looking at this one. She asks the man with concern, "this dog wont bite, will he?" The man sneers at her in response: "You strut around like you are doctors, if he bites I am sure you can handle it." Navdeep laughs this off nervously and proceeds to ask her questions. We leave as soon as she is done.

The rest of the day is fairly typical. Before I board a bus back to the city, we eat at Navdeep's. She tells me this Jat Sikh family is always very rude. When Navdeep first went to their house to check on their daughter-in-law who is nine months pregnant, the family snubbed

Navdeep. They told her they didn't want to give her any details, they weren't interested in any government services. The old man's words were, "we don't want to be in your registers." It is Navdeep's job as the ASHA to register every pregnancy and conduct antenatal visits, even if the family chooses a private doctor for tests and delivery. She explained to the old man that when she notes down details on behalf of the government, it is not only for services. It is also so there can be a record in the 'system.' Without registration, the pregnancy will be under the radar and later, so will the child. "How will you prove it is yours and not just some child you adopted," she told them, "don't you want a record that this is your child?" Navdeep rolls her eyes. As she scoops up her sabzi-roti into her mouth, she shakes her head, "it was SO difficult to get through to them."

It is notable that Navdeep has trouble "motivating" an upper caste family. They are dismissive of her, and of the government services she offers. She tolerates their hostility without letting it get to her, and keeps coming at them from various angles, hoping something will stick. Finally, she gets them with their desire for full propriety/property over their child.

When I visit this family with Navdeep, I find none of the bonhomie I saw in Jat Sikh homes two days ago with Guneet. Instead, there is hostility, consistent with Navdeep's previous experiences. By telling Navdeep she struts around as if she were a doctor, the man is reminding Navdeep about her occupational status—she is not a doctor—while also taunting her about the improbability that someone with her social profile—a poor, Dalit woman—could be a doctor. The term he uses is the Punjabi feminine *"doctorni*." The term is a forced feminization: the *'ni'* sitting awkwardly at the end, as though to call attention to how unlikely and ill-fitting it is for women to be doctors. In sarcastically declaring, "if he bites you I am sure you can handle it," the man reveals a mocking disdain for Navdeep's concern. It is not that he does not believe the dog might bite her. He simply does not care if the dog does.

Caste dynamics have not been easy to excavate with ASHAs. From the beginning of my research, I tried to center caste in my inquiries. I constructed my interview sample to include caste variation: I interview Dalit and dominant caste ASHAs equally, and my interview schedule tries to get at caste barriers through indirect questions (for example: "In your community, which households are the easiest to work with?") and direct ones ("Do you find it easy to work with women from other castes?"). However, the answers I get, and the field observations I make, do not tell a clear and simple story of caste-based discrimination. Part of this must have to do with my own lack of intellectual/personal standpoint (I am upper caste for all intents and purposes because my father, whose last name I have, is an upper caste Hindu). But part of this I suspect is due to the nature of caste in Punjab. Because of the historical influence of Islam and Sikhism, the puritanism of Brahmanism is not on stark display in Punjab. In parts of Punjab, reformist religious movements coupled with a long history of out-migration to the West have led to greater mobility for Dalits, compared to other parts of the country. Muktsar, however, is not in such a part of Punjab. Muktsar is in the Malwa sub-region. Here, Dalits remain less mobile and more tied to agriculture and their traditional occupations (Jodhka 2004, 2006). Caste persists, like it usually does, as social boundary, a combination of class and community (where you live, who you marry).

In my fieldwork, a significant manifestation of caste is how it stratifies health services. Upper castes opt out of public services, so it is the poor and non-upper castes who bear the brunt of an over-burdened public health system. In interpersonal interactions, I find evidence not of untouchability but of caste-derived power, a kind of relational clout that matters depending on both, the caste of the ASHA, and the caste of the client.

One sultry afternoon, I am sipping *chai* and hanging out in the postpartum unit of the civil hospital. It is close to 2 PM, and most ASHAs and nurse supervisors have left for the day. It is just

me, and Gurpreet, a very pregnant nurse who is flipping through one of many registers piled up on a long table. She is waiting for her husband to be done. He also works at the hospital. She is BC and he is SC, which makes their inter-caste marriage eligible for a cash incentive from the Punjab government. I know this because she had me write their application letter in English a few days ago.

Gurpreet is usually quieter than the other nurses who sit at this PP unit. But today, either because we are alone or because she is trying to return a favor, she is being chatty. She asks, "what exactly are you looking for in your research?" I launch into a longwinded answer: "I want to know how women become ASHAs, how their trainings are, how they learn, all the work they have to do, what difficulties they face, in the hospitals but also when they go house to house, which households they find it easy to work with, which difficult…" Here she cuts me off. "Look, ASHAs work the best with households that are like them, medium-type, like SC homes. Problems happen in homes that are either too hi-fi, like some General ones, or totally poor, *bhaiye*[6] type in *jhuggis* (informal settlements). Those are the hardest to motivate."

Community health worker (CHW) programs follow a community-matching logic, that workers who belong to the communities they serve can best identify and represent the concerns of those communities. The ASHA program attempts to match the ASHA to the dominant demographic where she is being appointed. A mostly SC village should have an SC ASHA. However, villages and urban areas are comprised of more than one caste or sub-caste. This raises the question of whether and how caste matters in ASHAs' interactions. In my fieldwork, I find Gurpreet's analysis to be spot-on. Most ASHAs, no matter their caste, report SC homes to be easiest to work with.

[6] Pejorative term for migrants from the poorer, Hindi-speaking states of Uttar Pradesh and Bihar.

This is Harjot, an urban SC ASHA:

> SC homes are the easiest. They are our people. They understand us. Big people don't understand, they only want private treatment. Okay, some General people will think, let's try the government hospital if it is free. But not everyone. People in *jhuggis* also don't listen. We have to really motivate them. Pay for them sometimes.

Joginder is a rural ASHA who is BC, and an office bearer in the ASHA union:

> When we go to educated, big homes, do you know what they say to us? They say (in a sarcastic tone) 'Oh look at this ASHA acting like some big madam. She thinks she can teach us! As if we don't know how things work.' They might hear us out. We will say: 'come to the government hospital, you will get such and such benefits.' But they will respond with: 'no, we know people in the private hospital and that is where we will go.' You know what I think? It's okay. Let them spend their money. We are here for the poor. They are arrogant about their money. They think the ASHA is small.

The experience that General homes hear them out but do not actually cooperate was echoed by several ASHAs. Rural ASHA Jaspreet put it like this, "They will not even deign to share any information with me. For as much as six months they will keep me hanging! They say, we don't need you. As ASHAs we are told to find out who is pregnant, how much their hemoglobin count is, etc. But these people are unwilling to disclose anything. Whereas SC women tell us immediately, I am x months pregnant, or my child is having xyz problem." Her troubles with "General category" do not end there: "Even in the hospital, we can put two SC patients to a bed. But General patients will really bother us. They want a bed to themselves. They don't care if there is an emergency. They want everything separate. They want running water in the washroom. They ask for this facility, that facility. If we tell SCs, this is how it is, you will have to cooperate, then they cooperate. But not General."

Most ASHAs I interview express their comfort with SC homes in familial terms, denoting kinship. Gurpreet, a rural SC ASHA told me: "They are our people, we can visit them anytime." Roop, an urban SC ASHA uses the word "brotherhood" to describe her experience in SC homes.

"They think of us as their own daughters-in-law. We are one of them." She adds that when she interacts with patients, she always thinks of how things were for her before she became an ASHA. Despite the lure from private hospitals, Roop tries as far as possible to bring her patients to the government hospital. She says it is because she has the same problems as her patients. Her daughter has persistent medical issues, treatment for which she has had to put on hold because specialized government care is far away in Punjab's capital Chandigarh, and specialized private care that is available locally she cannot afford.

A handful of ASHAs, however, said they found SC homes hard to work with. The ASHAs who said this were usually not SCs. Japneet, an urban ASHA who is BC told me she finds it much easier to work with General homes because they have time. "SC homes have to work everyday, so they don't come along with you easily. I have to make a lot of rounds of their homes. It is hard."

Shashi, a rural, upper-caste ASHA, explains the difference:

> Look, it is easy to work with General homes. But we like to help the poor. And poor homes are not easy to work with. SC homes are difficult, definitely. But they are the ones who need us. They think if their children get an injection, they will have problems. General homes don't have any issues with vaccination. They don't need to be explained these things. They have money. They have cars. They even don't care to ask us anything. They can manage on their own. It is the poor who need us. And for us to help them is a big sacrifice. It is a sacrifice. With polio drops they say, you are giving these drops to kill our babies. We have to listen to a lot! But still we work. It is for their wellbeing. So their children are not handicapped. SCs have more children. General have one or two children. General can give their children a good upbringing. SCs will have at least 3-4 children before they stop. SC is difficult.

The difficulties that Shashi describes facing in SC homes have been described by others too. But Shashi frames working with SC homes as a sacrifice. There is also a marked difference between the 'trouble' Generals give compared to SCs: Generals feel entitled to and can afford better care. They will often disrespect ASHAs by omission or commission, such as by withholding information or by calling their credibility into question. SCs, on the other hand, are likely to have

questions about treatment—like vaccinations—or be generally suspicious of state authority. Mostly though, they struggle to make time for hospital visits because they are poor and engaged in daily wage labor.

Harminder, an upper caste (Jat Sikh) rural ASHA, tells me she finds "less educated, SC homes" the hardest to motivate:

> In the hospital too, if someone is SC, uneducated, they cannot understand things. Like how to take medicine. The staff gets irritated with them. We have to explain things to them over and over. It makes a difference right when someone is intelligent, educated, from a good house where all his needs are met. He will understand at once. If someone is backward, from a backward home, it takes time to explain things to him. But I speak very gently, with love.

Harminder is a top performer. She has been felicitated by the district administration for her work as an ASHA. She tells me she is very familiar with people in her village: "With me, half the village has labored on my husband's family land at some point or the other, so they know us." In a sense then, Harminder has high motivational capital because she is easily accepted by the people in her village as an authority figure. This is on account of her caste status as a landed Jat Sikh.

Harminder's assessment of "good, educated, intelligent homes" (coded forward or upper caste) where people understand at once and don't have to be explained over and over again is very much a situated assessment. Certainly Jasleen, an urban SC ASHA, does not seem to have the same experience:

> In the General area, we keep waiting outside their homes, they don't open the door. Usually men open the door, and after taking one look at us, they shut the door. The women are like that too. They say, come only when our men are home, or come on Sunday. When the men are around, we cannot talk openly with their wives. Then there are men who say about us, these women are on a jaunt, they are just loitering. They are rude.

Jasleen alludes to General category men making derogatory comments about ASHAs being sexually available. The suggestion in these men's comments is that only 'loose' women would roam the streets without any 'real' work, like ASHAs do.

Apart from caste—which they name easily—ASHAs also identify other variables which make the work of motivating patients easier or tougher. Kamla, an urban SC ASHA, tells me she likes to work with families that own the homes they live in. She mentions people from other states, specifically UP and Bihar, who are seasonal migrants to Punjab for agricultural labor. Not only do they move frequently, they are loath to trust the government in a state where they are outsiders and treated with derision. There is also a language barrier; their mother tongue is Hindi or a dialect of Hindi, even though many pick up some Punjabi. While these migrants are likely SCs, for the ASHAs it is their status as non-Punjabis that is the most salient.

The association of lower castes and their occupations with uncleanliness, impurity, and a lack of respectability comes up in interviews. Here is what Sheenu says when I ask her if she would recommend this role to others:

> I would, but preferably to someone who is interested in service. Not to someone whose top priority is earning a salary. It needs to be someone who can get along with any caste. I once had to drink water at a *Maraasi* home. What to do? They are also human. You remember I took you to this home? (Reminds me which day and home it was) They greet me with a hug. They had insisted on *chai*, which I didn't drink but I agreed to have some water. I don't have any objection as such, it's just that they eat meat. They handle meat. They don't keep their house clean. That is my issue, no other issue. But they are my patients so… (trails off, nodding). All other ASHAs have trouble with *jhuggis* you know. They say the *jhuggis* don't listen to them. I don't have that problem. My *jhuggis* are good with me. Why, because I eat with them. One has to do it.

While Sheenu is at pains to tell me she has no real objections, she feels the need to explain at length how she came to drink water at a *Maraasi* home. It is a break from norm, understandable only because she is an ASHA and so "has to do it." I find it noteworthy that Sheenu brings up caste

as a social boundary, because no other ASHA does. Sheenu may have more caste anxiety than the others; she is SC. She married and separated from a General category man, a Brahmin, and now states her caste as General. During *karvachauth*,[7] for example, she read out the *katha*[8] for her neighbors, declaring that she is a *panditayan*.[9]

Caste also comes up in my interview with Rajveer, a General category rural ASHA. From the first time we met, Rajveer has been expressly warm. When we run into each other at the hospital for instance, she strokes my face, embraces me, and asks me to come visit her home. She tells me she doesn't know why, but she feels a lot of maternal love for me. During her interview she is unusually frank. Rajveer's only child, a son, is away in Australia. He has not returned home for about five years, which makes me think he is undocumented. She tells me she feels listless at home because her son is gone. When I ask Rajveer if she would recommend this role to others, this is what she says:

> R: Yes, I would recommend it. (Laughs) But who will want to become an ASHA and do all this running around? People tell me, everyone cannot run around like you do. If someone wanted to be an ASHA, I would say, yes try it out for yourself. Madam, among General, people do not get into this line. Big people do not get into these things. It is people like us, who are lower in status, who do these things. Someone with 10 or 15 *kilas* of land will not get into this. They don't approve of working outside home.
>
> Me: But you are General…
>
> R: Yes, we are General. But we have less wealth. Our land is small, 4 *kilas*. Only people with less money become ASHAs. People who are landed and wealthy don't become ASHAs. They will say, it is too much running around. And they say, you have to go around with poor people. At night! They don't like that. They frown upon it. They don't let their women out alone. People think like this. But not in my family. You know how the work is. You have to go at night if there is a delivery. My family is fine. My family is very good.
>
> Me: Do other General category people pass comments on your work?

[7] A Hindu festival, wherein observing wives fast for a day as a way to pray for the long life of their husbands.
[8] A story-telling ritual. As part of the *karvachauth* festival, women gather in the evening to listen to the origin story of the fast.
[9] Priestess, really wife of the priest. Signals Brahmin caste status.

> R: Yes they do. They tell me, what is this dirty work you have got into, just leave it. I tell them, I can't leave it, it keeps me occupied, I enjoy it. I am attached to people. I have come to know people well now. I can't leave this work. My brothers and sisters tell me, leave it. But I don't listen to them. I don't want to leave.

Sheenu and Rajveer convey versions of the same concern. By insisting on cleanliness and avoiding meat, Sheenu may be aiming to preserve the sanctity of her new and shaky position atop the social hierarchy. Rajveer, on the other hand, is *firmly* upper caste. She explains plainly why her caste brethren look down upon her work. The work of an ASHA forces women out of the sanctum of their homes, on terms—at odd hours, mingling with lower castes—that their families find unsavory. It is Rajveer's lower class status than other Jat Sikhs that forces her family to be different.

Chapter 3: Persisting as ASHAs

It is the last day of a five-day ASHA training on maternal and newborn health and nutrition. The training is being attended by 40-odd ASHAs from all over the district who missed this module when it was previously taught in their blocks. Most of them are recent appointees. I have been making a special effort to sit with the ASHAs from the blocks where I am conducting fieldwork (I count five in this training). But during the breaks, I chat with whoever will speak with me. It is tea break now. The ASHA sitting right in front of me turns around and starts talking to me. She has thick glasses on, and looks like she is in her forties. She seems quite outgoing. "You know I have been to Delhi once! But we stayed close to the railway station. There was a big market there… (*Paharganj*, I interject enthusiastically) yes yes, that's probably it, I don't remember the name. We couldn't go around much, we had another train to catch." You should come again, I say, there's so much to see in Delhi. "Yes I want to. I will when I have some more time. Right now I am very busy. I have to go to PGI every week." PGI[1] is a renowned public hospital and teaching college in Punjab's capital, Chandigarh. Without thinking I ask, why have you been going to PGI? Without skipping a beat, she responds, "My daughter is admitted there. She has lost vision in one eye. Her in-laws usually hit her. This time they hit her very hard. So, I have been visiting her." She spins back around because Amarjot sir, the trainer, is about to begin. I am a bit stunned by how casually I have been informed about a major incident of domestic violence. But I just reach for my diary and start taking notes again. The next topic is Acute Respiratory Infections.

About thirty minutes in, the conversation is waning. Someone in the front cracks a joke, and we are properly derailed. Amarjot sir is good-humored and even-tempered. He remarks, we

[1] PGI is shorthand for PGIMER, or the Post Graduate Institute of Medical Education and Research.

should all enjoy this time because no one knows what the future brings. He tells the room about someone in his village who just lost their son in a motorbike accident. Immediately, the same ASHA sitting in front of me pipes up, “Sir, on the surface everyone looks happy. But if you ask, you will know just how much people are grappling with on the inside.” Amarjot sir nods in agreement, “This is correct. Time is very dangerous. Now see, you all go to your sub-centers, you should be light-hearted and easy. Laugh, joke, be friendly, spend your time well. When you go home, there is only tension and more tension. Right? In everyone’s homes.” The woman nods vigorously.

I look around. Most of the room is nodding and murmuring in agreement. Now Amarjot sir asks them how they have liked the training, and how they like being ASHAs thus far. He calls out the names of the blocks, and the more vocal ones from each block respond. The first one to respond is an ASHA from Gidderbaha block. “I would say it is very good sir. It has brought us out of the home. Earlier, who did we even know? Now, we have become connected to so many people. The biggest thing is that we don’t have to ask anyone for money now. Earlier our families would say, we earn and give you money, you don’t bring anything. Now with a job they respect us, people in the village respect us.” Amarjot sir adjusts his stance to face the room. He says, “It makes a big difference to do a job, doesn’t it? Anyone can do housework. You used to do housework earlier, you do housework now. But after becoming ASHAs, now you know how to talk, how to conduct yourselves. Your personalities have changed.”

The ASHA from Gidderbaha continues: “Our knowledge has increased sir. People come to us when they need something. They say, let’s ask the ASHA about injections. Let’s ask the ASHA about delivery, about treatment, de-addiction, pension… They respect us sir.” Amarjot sir: “Everyone wants respect. Whether you are a man or a woman. We all want respect.”

Responses by two other ASHAs are in a similar vein. One of them says, “Now people actually consider me educated!” Amarjot sir concurs: “Everyone does housework, whether you are BA, MA or illiterate. Then what is the point of a qualification? There is only point when you step out of the house.”

The ASHA from Gidderbaha pipes up again: “Now they all call me madam. (Mimicking) ‘Where do you work madam? Where have you been appointed madam?’”

Amarjot sir: “When we stand in front of someone, it all boils down to our personality, no matter how educated you are. The person looking at you should say, this looks like a working woman. It looks like she is employed somewhere. It looks like she has a job.”

The Gidderbaha ASHA: “Sir even when we go shopping, they show you things according to your personality sir! If you look impressive, they show you nice things. If you look like, whatever (laughs), then they will show you things that are whatever too!”

Amarjot sir is laughing now. Navjot, a young and jovial ASHA who is sitting in the front row, seems to have caught his eye. He asks her to stand. He says to the room, “Look at her. Her husband passed away, but today, she is so capable that she can raise her family. We have come to the health department to learn, to do service, but also to feed ourselves right, to help ourselves financially.” I look at Navjot. She is looking down, so I can’t make out her expression. Amarjot sir asks, do you have anything to add? “No sir, that’s all.” Navjot says softly. He signals that she should sit. We break for lunch, after which another trainer takes over.

During lunch, everyone seems warmer somehow. The morning’s discussion seems to have put everyone in a good mood. It had an air of genuine participation and feeling. It was spontaneous, which made it stand apart from the rest of the training’s lecture-and-questions format. Although it brought up deeply gendered experiences, gender seemed to be erased in the very moment of

invocation. Amarjot sir's statements ('at home there is only tension' and 'everybody wants respect, whether you are a man or a woman') apply to women in a qualitatively different way than they do to men. When the ASHA whose daughter has been hospitalized by domestic violence identifies and commiserates with Amarjot sir's story about a parent losing their son to a motorbike accident, the moment disguises the gendered difference between these forms of violence: domestic violence and a road accident. Amarjot sir also sets up a binary between house work and real work. He constructs housework as something anyone can do; for this reason, it apparently nullifies your educational attainment. He constructs employment as the only way to *realize* your education. Of course, this is ironic because the Indian state denies ASHAs the status of employees.

And yet, there is something here. The women in the room really responded to Amarjot sir. As he editorialized on the testimonies he sought from the room, everyone was in full agreement with him. Over the course of my fieldwork, I realize why. The role of an ASHA is extremely rewarding for the women in it, primarily because it brings women out of the home—connecting them with a lot of people—while earning them respect in the home, by earning them money. In the next section, I explore the rewards of the ASHA role, gleaned mostly from the following interview questions: what has changed in your life since becoming an ASHA; what is the best part of being an ASHA; can you tell me about one moment when you felt very happy or proud that you are an ASHA; and would you recommend this role to others.

REWARDS OF THE ROLE

> The best part of being an ASHA is that the people in my area consult me for everything. Even for marriages they take my advice. They tell me, 'this is the boy, this is his work, do you think it's okay?' This gives me a lot of joy. That my patients consult me before doing anything. Even when I can't help them! A heart patient will show me his reports. I don't understand those reports, and I'll admit it, but I will go through them at least once. My patients trust me so much. See, when they come to the government hospital with me, I get them free treatment that saves them something like Rs. 10,000 (USD 143) that they would

have spent if they had gone to a private hospital right? I become like a kind of god for them!

Sheenu enjoys the respect that her work wins her from people. Her patients see her as someone knowledgeable and trustworthy. They consult her on a range of matters. Sheenu is clear why this is; she readily admits she cannot understand a heart patient's reports. It is her position as a community health worker, connecting patients to free government services, that makes her "a kind of god" in their eyes.

Navjot is a recently appointed 32-year-old rural Dalit ASHA. She lives with her son and in-laws in a household of seven. Her husband passed away a few years ago, and this is her first job. I ask Navjot what has changed for her since becoming an ASHA:

N: I have learnt so much. Some of it is, like, I know about diseases now that I did not know earlier. After my husband died, I had no employment. But now I can support my son. I can give him a good education. You should see, I speak to him like I am a doctor (laughs)! See, if I work, I will earn. I have something now.

Me: Can you tell me about a moment when you felt proudest of your work as an ASHA?

N: When you save the life of a mother or a child, it feels very good. Recently someone's child was born very sick, with an infection. I helped them get to another hospital for the treatment they needed. It made me very happy that, because of me, because of my work, a mother did not lose her child that day.

Navjot finds fulfilment in her work as an ASHA. This fulfilment stems from intellectual rewards, monetary rewards, and from emotional rewards. In experiential terms, all these rewards are bound up together for Navjot. Navjot's own trajectory intersects with the nature of her work to create a unity of intrinsic and extrinsic rewards. Her position as a young widow bringing up a son in her marital home intensifies the gratification she feels when she helps save another woman's child, or when she provides—however modestly—for her own. I found this was a common pattern among many ASHAs.

Amanpreet, an urban ASHA (BC) since 2015, is a god-fearing woman. She is deeply religious, works hard at her role, and has managed to pull in her sister and sister-in-law also as ASHAs over the years. She is 39 years old, has studied till 10th grade, and has two children.

> My objective behind becoming an ASHA was to be able to serve people. Whatever religion one follows, all religions say that we should serve people. With this ASHA work we earn good karma, and we can feed ourselves. This is why I like working for the government.

Amanpreet uses a colloquial rhyming idiom to explain to me that the work of an ASHA has both *sewa* and *mewa*. *Sewa* is service. The literal translation of *mewa* is nuts (called 'dry fruits' in India), and it refers to earning the fruits of one's labor. Amanpreet is clear that one does not substitute for the other. Both service and earnings matter. That they come together in the work of an ASHA is what is most attractive about the role.

Navdeep, a 31-year-old Dalit rural ASHA since 2010, says this when I ask for her thoughts on the ASHA program:

> The government has done very well by appointing ASHAs. Half the village has survived because of us! Earlier so many mothers and children would die from something or the other. Now people are getting services at their doorstep. People did not even know these services existed! No pregnant woman used to get a tetanus injection. No one had birth and death certificates made. The ASHA program is a very good program.

Navdeep articulates occupational pride at the role of ASHAs. She has a clear sense of all that this workforce is doing for the health department, and of how socially significant the outcomes are towards which they work. In official gatherings of the health department, ASHAs are constantly reminded by staff about the importance of their work. They are also often praised for being the "backbone" of the department. This rhetoric may not reflect in their working conditions, but it gives ASHAs a sense of achievement. When I ask Navdeep what her recommendation to the government would be for the ASHA program, her answer comes quick as a flash: "Salary! You

have seen how much we run around and how little we are paid. It is not fair to our families. Give. Us. A. Salary!"

24 years old Jyoti has been an urban ASHA for only six months when I interview her. She is an upper caste Hindu (Thakur) woman who has studied till tenth grade. She reports that her husband and her combined monthly income as INR 20,000 (USD 285). This is her first job.

> I am fulfilling many roles in life now. Earlier I stayed home, so I would sleep, sit around, eat, whenever, however. Now I keep time. I wake up at 5 in the morning in the summer, at 6 in the winter, quickly finish all the housework, and then run! These are all changes in my life since becoming an ASHA. (Pauses) Good changes I would say. I feel like I am doing so much now. I return home in the evenings. My children are happy to see me. They wait up for me now. Not like before when we were together all day (laughs)! Now they ask me, (mimics a baby's voice) 'mama what have you brought?' I like to be able to bring something back for them. Something small. It feels good.

Jasleen is 33, has studied till tenth grade, and lives in a household of eight in her marital home. Jasleen has been working as an urban ASHA for three years now. She is from the Dalit community (Chamar). She has four daughters, and an out-of-work husband. Before she became an ASHA, her father-in-law, who works as a cobbler, was the sole earning member of their family.

> You know other people—like my neighbors—tell me that earlier, before becoming an ASHA, your face was always pulled down, you were so consumed by your problems. Now you go out of home, you interact with so many people, it has made such a difference to you. People tell me, you no longer have time for chit-chat! You have become so busy! I think it is better to be busy. I enjoy working. When I used to be home, I wouldn't even find time to comb my hair! Now I finish all the housework and leave. I find it hard to be at home. A lot has changed. There is less tension at home now. Earlier my in-laws would say, she doesn't work, how will we support her and her children? Now as an ASHA, I work here and I work at home. I give them money for household expenses. So now they feel differently. Like, earlier they wouldn't talk to me properly. Its none of that now. They are happy with me. They are good to my children. We live better now.

Like Jyoti, Jasleen articulates the dispositional, monetary, and emotional rewards of paid care work. But because of the difference in their positionality, these rewards take on a different meaning and valence in Jasleen's life. For Jasleen, being an ASHA is not only a matter of doing

more with one's day, or buying small gifts for one's children. The state of Punjab is notorious for its skewed child sex ratio, which is the result of a culture of son preference. Families go to great lengths to eliminate daughters, from aborting female fetuses to infanticide by neglect. After becoming an ASHA, Jasleen can provide for her four daughters. Her father-in-law is no longer the sole earner for their family of eight; she now makes INR 3000-4000 (USD 42- 57) a month, as much as him. This has dramatically improved the climate at home. The lightness of manner her neighbors note in her is probably related to this.

Many women I interviewed had studied further since becoming ASHAs. Sometimes women do this to fulfil the official requirement that ASHAs should have studied till 8th grade in rural and 10th grade in urban areas. But I often found that after becoming ASHAs, women aspired to, and were able to, study more. Jaspreet, a rural Dalit ASHA since 2007, joined in the hope that she would become tenured and salaried one day, like the other government jobs she has seen around her. The money was not much, but as she put it, "it was more than what my husband earned alone, so I thought more is better for the children." With time, she did better and better as an ASHA. Her family's ambitions grew alongside hers.

> The biggest change in my life is that my family lets me leave home now. They trust me. They know I have a job, I have responsibilities. See, I don't have to stay an ASHA forever. I can become an ASHA supervisor, and why just that, I might become a nurse. I am studying for it. When I joined as an ASHA I had studied till the tenth grade. Then I thought, why not become a supervisor? I completed twelfth grade. Now I have this dream, of becoming a nurse, so that is what I am studying for. I am filling the forms. My exams are this month. This is the best change in my life. My family cooperates with me now. They tell me, yes you study further.

Roop, a 34-year-old mother of two, is also studying alongside. In her case though, it is self-driven. Roop's husband cannot hold down a job because of his addiction. What she most appreciates about her work as an ASHA is the small but stable income it gives her:

> I pay for our rent. I pay for my children's school fees. It is not much money. But now I can borrow money because I know that the next month something will come.

Apart from a couple of monthly department meetings and weekly immunization drives, ASHAs' schedules are open. Their hours for home visits or bringing patients to the hospital are not fixed. This flexibility means that although they are on call 24/7, they also have more autonomy over their time. As a Dalit (Mazhabi Sikh) woman living in a nuclear family and yet to complete high school, Roop prefers this to other labor market options available to her.

> When I would go to the fields (for agricultural day labor), sometimes there is work and sometimes there isn't. Here you know that every month, month on month, you will make between 3000 and 4000 (USD 43-58). I have worked in a factory too. There, if you need a day or two off because of an emergency at home, they don't allow it. They tell you not to come anymore. So I prefer this (ASHA) work… Otherwise I would be out all day. Leave at 8 in the morning, return at 6 in the evening. Here I can be done by 3 or 4 and return home to my children.

Most of the ASHAs in my field are working outside home for the first time. Moreover, many are struggling to provide for their families because they are either widows, or have been abandoned by their husbands, or have husbands who do not contribute to household expenses on account of unemployment or substance abuse. The rewards these women experience must be situated within this gendered life course context. ASHAs complain about the low and erratic nature of their incentive payments, but they are glad to be making their own money. They are especially grateful to be able to spend on milk or school fees for their children.

While this gendered life course context is common, there is variation in the meaning wages have for different women. The significance of or returns from wages can be lesser or greater for ASHAs depending on class and caste. For Dalit women who are marginalized on account of their caste, class, and gender status—with all the disadvantages this engenders such as lack of home ownership and low educational attainment—the returns of low-wage care work seem to be greater

than for women in more advantageous social positions. The upper caste ASHAs appreciate their earnings as disposable income because typically they are not the sole earners for their households.

While the upper caste women working as ASHAs are from backgrounds less wealthy than other upper castes in their community, they are still wealthier than Dalit ASHAs. This is confirmed for me in a conversation with the district ASHA coordinator, Sukhdev. For ten years now, Sukhdev has been overseeing the 400-odd ASHAs in all of Muktsar district. He tells me many "General category" women joined when the post of ASHA was first announced, assuming it would be a regular government job. They left when they realized what the work—and pay—involved. I ask Sukhdev what he thinks motivates the women who stay on as ASHAs:

> They are poor. ASHAs are not usually from General category, rich families. 75% of the motivation is the money. They work for the incentives. The other 25% I would say, is that they have become so connected to people. There is prestige in this. People listen to them. They have made a name… these things, I would say.

The experiences of ASHAs reveals the interplay of gender, class and caste matters in low wage care work. Recent scholarship highlights the heterogeneity among care workers and delineates the varied mechanisms producing care penalties, such as individual and job characteristics, occupational closure, and wage-equalizing institutions (Budig et al. 2019). Like with wage penalties, I find heterogeneity also matters for wage "returns," or rewards. This suggests that race/ethnicity, in this case caste, matter not only in creating opposing poles in care—high paid nurturant care jobs associated with white, professional or semi-professional women, and low paid reproductive care work, associated with women of color and immigrant women—but also within the same pole, as with ASHAs who are all low paid care workers.

BOOSTING INCOME FROM NON-ASHA WORK

Earnings serve as the foundation from which one experiences emotional fulfilment in providing for one's children, occupational pride from saving lives and earning respect, and intellectual growth from learning and studying. Significantly, ASHAs earn not only from their wages (incentives), but also through the networks they gain as ASHAs.

Prabhjot is a 34-year-old rural ASHA who lives with her in-laws, husband, and two children. She belongs to a mid-level caste (BC). Prabhjot's in-laws are day laborers, and her husband is a tailor. She has studied till the 9th grade, and joined as an ASHA in 2013.

Me: How much do you earn per month as an ASHA?

P: Not much. Between 2500 and 1500 (USD 36-22).

Me: Do you have any other source of income?

P: No. I used to go to the fields for agricultural labor, but not anymore, not since becoming an ASHA. Now I do parlor work alongside.

Me: Parlor work?

P: I go to so many homes right. I tell them or they ask me, madam you can do parlor work too? Then I get requests for threading, facials, etc.

Being an ASHA requires Prabhjot to regularly go door-to-door in her village. She draws on this network to boost her clientele, and income, as a freelance beautician.

Rajveer is an urban ASHA (BC), who also does "parlor work" on the side. In her interview she tells me that being an ASHA augments her parlor income: "I didn't leave the house earlier, and now I know so many people, so naturally." In the past, Rajveer also supplemented her income by babysitting for two staff members—a doctor and a nurse—at the hospital where she reports as an ASHA. It began with the nurse's baby. Then one day the doctor saw her watching the nurse's baby during hospital hours, and invited her home after hours to help with the doctor's infant child.

Before Rajveer, another urban ASHA, Kamla, who is Dalit, would babysit for the same doctor for Rs.. 100 (USD 1.5) a day. During my time in the field, Kamla was no longer babysitting. Now, she sells cosmetics and costume jewelry on the side. Every couple of weeks, when she has procured a new stock, she brings her wares in a worn-out plastic bag to the hospital, and the nurses and other ASHAs buy from her. Kamla has been an ASHA since 2015. She returned to live with her natal family in Muktsar when her husband abandoned her and their son many years ago. A few days before our interview, a judge rules in Kamla's favor in the maintenance case she has been fighting. Kamla is pleased that the long battle is over. She reflects on the distance she has come since becoming an ASHA.

> I know so many people now. And I get along well with everyone. Earlier, I was scared of an injection! I used to say, I don't want to go to the hospital. For my own delivery I never got any injection, but look at me now getting other people injections! I am proud of myself. I started this work under compulsion. But now I support my son. So my family is good to me. My neighbors greet me well, they respect me. What could be bigger than this?

Later in the interview, Kamla uses the word *duniyadari* or worldliness to encapsulate what being an ASHA has meant for her. She reminisces that she became an ASHA out of "compulsion," but is today proud of how she moves through the world. She has made the best of bad circumstances.

Similar to Kamla's entrepreneurialism with cosmetics and costume jewelry, some ASHAs have sewing machines at home and stitch salwar-suits to make additional money. One such ASHA, Ikmeet, enquires about my baggy salwar-suit during her interview. When I tell her I bought it ready-made in Delhi, she shakes her head disapprovingly and remarks, "that is why it doesn't fit you well, next time let me stitch it for you and you see the difference!"

While the overwhelming majority of ASHAs have low educational attainments, the handful of ASHAs with higher education also make use of their connections as ASHAs. Kirtan is the most

educated ASHA in my field. She is an urban ASHA, Dalit. She has two masters degrees, and is qualified to be a school teacher. She tells me she is waiting to find tenured employment in a public school—her dream job—and that being an ASHA is only a stopgap. She thinks of an ASHA's work as something "anyone can do, even women who have only studied till the 8th grade." In addition to being an ASHA, Kirtan tutors schoolchildren from her home. When I visit her one day, all seven of the enrolled children were in attendance. Four of these were children of other ASHAs.

The ASHAs in my field are engaged in a range of side hustles. Some can be categorized as somewhat minor—like Preeti who has struck a deal with a local mobile shop to serve as a "guarantor" for anyone from her neighborhood who wants to pay for a phone in installments—and some as relatively major, like Babbi, who was hired by the field office of an international NGO for a child marriage prevention project that ran for a couple of years. The field office was impressed by her reach in the village where she lives and works as an ASHA. In each of these cases, women capitalize on their expanded social networks from being ASHAs.

Being an ASHA does not just afford a small but stable income in the form of money earned from completing official incentivized tasks. Crucially, in addition to money, it affords the means to make more money. ASHAs do this in one of two ways: one, they use the expanded social networks that being an ASHA gives them to boost other work, like parlor work or tutoring, or in some cases, to advance non-governmental or governmental careers. Two, ASHAs also make money by taking patients to private hospitals and earning commissions.

EARNING COMMISSIONS AS ASHAS

Harminder is one of the highest-earning ASHAs in the district, for which she has been felicitated by Punjab's health department. Harminder is 37, an upper caste Sikh, who lives with

her husband and son. She is unusual in that she is from a relatively privileged family that owns five acres of agricultural land.

> Me: Do you know private hospitals well?
>
> H: I don't go. I don't take my delivery cases to private hospitals. My village is poor. They prefer using government facilities.
>
> Me: So you don't know private hospitals?
>
> H: Yes, yes, I know them. I know them very well. Private doctors treat us very well. You know how it is here (in the government hospital). The out-patient department is so crowded. No one has any regard for anyone. Especially ASHAs. They think nothing of ASHAs. But private doctors chase us! Because they are greedy. They give us gifts. They call us again and again. They ask us to bring them cases for commission. But my village is poor. I bring my patients here so they don't have to pay for treatment.

When I ask Harminder if she knows private hospitals well, she straightaway denies going there. This is unsurprising because ASHAs are constantly told by their supervisors in the health department not to take patients to the private sector, and to do their best to bring them to government hospitals first. ASHAs, after all, are appointed by the government to service poor and vulnerable populations. But India's large, and largely unregulated, private health sector has identified ASHAs as community gatekeepers of a sort. ASHAs are the only health department workers who go house to house, so they know the health needs of their community intimately. They have the power to push patients into private hospitals, and private hospitals lure them to do exactly this. As Harminder tells me, private hospitals pursue ASHAs by repeatedly calling them, offering them attractive commissions per patient. Private hospitals also throw "parties" for ASHAs. I was around for the Hindu new year, Diwali, when different private hospitals invited ASHAs for tea and samosas, and/or gave them small gifts like crockery. Harminder is careful to tell me that her village is poor and she brings her patients to the government hospital. She wants me to know that although she knows private hospitals well, she does not respond to their overtures.

Most ASHAs in their interviews with me denied going to private hospitals at all. However, the longer I stayed in the field, I saw that most ASHAs were in fact going to private hospitals, for myriad reasons and often in the interest of their patients. Thirty-four-year-old Harjot lives with her husband and two children. Harjot is Dalit, and has been an urban ASHA since 2015, when urban ASHAs were first appointed.

Me: Do you know private hospitals well?

H: Yes, there is one doctor. At Metro hospital. I know him very well. I go there, but only once every couple of months, if there is a case.

Me: What kind of case?

H: A delivery case, someone who says they don't want to go to the government hospital. Then I take them there. I have taken family members there too. My sister. My neighbor. I got these deliveries done for the lowest possible price.

Me: Does Metro give commissions?

H: Sometimes. Yes, they give commissions if the price of the procedure is more. The money has to go from the patient's pocket after all. If I know the patient is poor, then I don't take commission. Never.

Here, Harjot tells me she has ties to one private hospital. One can assume that her estimates about how often she goes there are conservative. Significantly, she tells me she takes only patients who can afford it, and has taken people close to her, like her sister and neighbor, getting them the "lowest possible price." Harjot is trying to not appear predatory. In the field I regularly heard about 'bad apples' among health department personnel, including ASHAs, who would either exploit poor patients by demanding money to get their work done, or would redirect naïve and desperate patients to private hospitals for commissions.

In the case of ASHAs, the 'bad apple' thesis may be accurate, but it paints an incomplete picture. ASHAs are also routinely confronted with patients who explicitly do not want to use

government facilities—because of the poor quality of care, for instance—or who want to use government services but are discriminated against and effectively denied treatment there—if the patient has tuberculosis, for instance. The question of how legitimate the circumstances are under which ASHAs activate their private hospital links is beyond the scope of this chapter. But that these connections and commissions exist, and are activated, demonstrates the monetary rewards apart from wages that ASHAs accrue as paid care workers.

Navdeep has worked as a rural ASHA for a decade now, since the initiation of the National Health Mission when ASHAs were first recruited. Navdeep is Dalit, 31 years old, and a mother of two. Four months before our interview, she was appointed as PRO, or Public Relations Officer, for a privately run rehabilitation center. Drug use is rampant in the state of Punjab. As a PRO, Navdeep's role is to tell the addiction patients she comes across about the center, to try to bring them in. She is also to tell other ASHAs about the center, so they can send the addiction patients they come across there as well. Navdeep makes 6000 (USD 86) a month as a PRO, apart from the 3000-3500 (USD 43-50) she earns as an ASHA.

> Me: Apart from PRO and your ASHA wages, do you have any other source of income?
>
> N: Yes, earlier many people would go to private hospitals with us. Now it is less. Now most people know that if they take an ASHA with them to private (hospitals), the ASHA will get a commission out of their fees. But we still get scans. We earn from scans.
>
> Me: Does it help to go a private hospital with an ASHA, or would it make no difference if I went by myself?
>
> N: No, it definitely makes a difference. Because an ASHA can get you a better deal. She can speak to the doctor to reduce the price. If the patient goes on their own, the doctor will charge however much the doctor pleases. But if the patient goes with an ASHA, the doctor knows the ASHA will be back with more patients. He knows that if he charges too much, the ASHA can easily take the patient elsewhere. See the ASHA knows many hospitals. But the patient does not. Without the ASHA the patient is trapped. That is why doctors charge more reasonably when the patient goes with an ASHA.

Navdeep tells me ASHAs' earnings from commissions have reduced because people have "wised up" to the arrangement. But ASHAs still earn from what is colloquially called scans, or ultrasounds during pregnancy. Women are supposed to get at least two ultrasounds during the course of a pregnancy. However, the post of radiologist was lying unfilled at the government hospital in my field, which meant patients had to get their ultrasound scans done privately. In private hospitals, the patient is charged a more-or-less fixed sum of Rs. 500- 600 (USD 7-9) per ultrasound, whether she is accompanied by an ASHA or not. But if an ASHA brings her patients to a favored hospital, like Harjot goes to Metro hospital, she can make Rs. 100-150 (USD 1.5-2) per scan, without the hospital charging the patient more.

Navdeep also points out that ASHAs' links with the private sector can be beneficial to patients, because ASHAs can use their influence with private hospitals—their ability to bring in a constant stream of patients—to bargain on behalf of patients in need. In my field, I saw a couple of instances where this played out; in one case, an urban ASHA negotiated with a private doctor, on behalf of a tuberculosis patient in her third pregnancy, to reduce the cost of her cesarean-section.

Moreover, the public health system is under-equipped, and relies on ASHAs' private sector links. For instance, the district hospital in Muktsar does not have a neonatal ICU. If babies are born with complications, patients are asked to go to private hospitals for treatment. This is where ASHAs, and other hospital employees, come in to advise the patient on which private hospital to use. Currently, part of the district hospital in Muktsar has been moved to another venue due to coronavirus. On a recent phone call, Navdeep told me that when the other ASHA from Navdeep's village went to this new venue with a delivery patient, she was told they were not yet set up for a c-section, and that she should take her patient to a private hospital.

MENTAL HEALTH

For women who persist as ASHAs, proximity to their community affords many rewards. But proximity is not always rewarding. ASHAs are the only members of the health department who necessarily live among the people they serve. As community health workers, they must be from the "community." For rural ASHAs, this means they serve the village they belong to. For urban ASHAs there is more flexibility; they may live in, or close to, the neighborhood they serve. This proximity cuts both ways. While it allows for intimate social ties that ASHAs can capitalize on, I also find that it puts ASHAs' mental health under chronic strain. Sandwiched between communities that are close to them and a health system that is compromised, ASHAs face immense stress. Their fear of losing their position, reputation, or both hangs over their heads like a sword. Technically, an ASHA can only be removed from her position if she has not been performing (assessed through her incentive earnings) for three consecutive months, without any explanation. But loss of reputation is another matter. It is a chronic and sometimes toxic fear an occupational hazard they are not allowed to forget.

For instance, during an ASHA training in January 2019, the trainers bring this up. The morning's topics are being discussed just before the room is to break for lunch. Out of nowhere, Amarjot sir switches tracks. He says to the room: "Doing something underhanded might earn you 5000 a month, but you make that much anyway. Learn to control yourselves. Right now, people in the village seek you out. You can lose all that. You can lose your reputation. You might make a little less money, but you are *sarkari* (of the government). Act like you are *sarkari*." The room is silent.

Later on in the same training, the issue is brought up again, this time by Sukhdev. He is going over a check list for home visits when he pauses to say, "I am not blaming any one person,

but for the sake of commission, we should not waste a patient's time and money. If the doctor recommends a scan, then yes, please take the patient for a scan. But don't get a patient scanned for no reason. I don't want to hear that you don't go to private places (many nod in agreement). But people trust you. Don't break that trust. Don't misguide them." These words from Amarjot and Sukhdev carry weight. I think they find their mark because the room takes them in without comment. There is no chatter, no arguing, and no joking.

However, behind these tacit reprimands against "breaking patients' trust" lies a far more complicated picture. The trainers are trying to set limits to what they see as ASHAs' greed. They caution against unbecoming conduct that can cause one to lose face. But ASHAs are painfully aware that they can lose face. They are very much bound by their position, or rather lack of position. They are easy scapegoats for an overburdened and under-staffed health system; blamed for outcomes they are quite powerless to control. When I interview Jaspreet, she has a lot to say about this:

> If there is any problem, for instance, if a woman dies while giving birth, why, because she was severely anemic. Because her hemoglobin was too low. What is the first thing they do? Summon the ASHA. (Speaking in a gruff voice, imitating a man's)'ASHA, why was her Hb low? ASHA, you are to blame. This has happened because of you.' The civil surgeon will say this. We are given an earful from all quarters. (Mimics again)'ASHA you failed to bring her Hb up. That is why she is dead.' If a child suffers from malnourishment, 'ASHA, you did not give him his iron doses.' This happens not just with the civil surgeon, but also with hospital staff. If a patient comes with one test report instead of two, 'ASHA, you did not get her tested properly. ASHA, you are at fault.' Sometimes a patient will call me just before she is about to deliver, with only ten minutes to go. I will call the ambulance immediately but the woman will deliver in the ambulance. As soon as I reach the hospital, the staff will tell me off. 'ASHA, you delayed this patient.' (Her tone becomes desperate) The ASHA did not delay the patient! The patient informed the ASHA too late that she was in pain! The whole department blames the ASHA.
>
> In Jaspreet's experience, the buck always seems to stop with the ASHA. There can be many gaps and slips in the course of delivering reproductive health care, but ASHAs are made to feel like everything is their fault. It is a burden that weighs heavily on Jaspreet. I ask her if she has sometimes felt this work is too hard, that maybe she should do something else:
>
> J: I feel like that every day (laughs). Ten times a day (cackles)!

Me: Can you give me an example?

J: Once I brought a woman to civil for her first delivery. 19.10.2018. Everything was ready. The staff nurse was examining the patient. The class 4[2] should have been helping her. But she was sitting away, barking instructions at me. I did everything they said. I told myself, my patient needs it, she is in a lot of pain. I can fight with this class 4 later, but right now I need to save the mother and child. The child was delivered. I have been in this line of work for so long now, I know how treatment should go, and I know the side effects of everything. The nurse was supposed to give half Pitocin, but she was giving full. I knew this will affect the baby. The baby will be blue, the baby wont cry. But I also knew she will fight with me if I say anything, so I couldn't stop her. The baby weighed 2 kilos and 700 grams, born at 12.37 PM, but the baby didn't cry. I told them, please give this baby oxygen. Please do suction, but the staff nurse was new, she couldn't find the suction tube. I said (in a pleading tone), it has been 15 minutes and this baby has not cried, will you please call the doctor?! The nurse just kept massaging the baby's back. The baby had not cried for 15 minutes! I knew these women would just wrap the baby and hand him over to me. But what will I do? How will I go outside the room with a dead baby? I insisted on calling the doctor. This one nurse trainee finally went to emergency to fetch the doctor. He came within 2-3 minutes. In that time, thankfully, the baby started whimpering, started drawing breaths. The doctor gave the baby oxygen. That is what I was saying before the doctor arrived. I even said, if nothing else you give me a gauze and I will give this baby mouth-to-mouth oxygen. I know you are supposed to do that. I know you are not supposed to hang the baby upside down, why are you doing that? We have been by doctors: you are not supposed to turn the baby upside down because the blood rushes to the head and the baby becomes abnormal. The nurses did not care about normal-abnormal. They just wanted the baby to cry. When the doctor came, this nurse said to me sarcastically, with folded hands, do you think you know more than me? I answered back, yes I know more than you, when you knew there was going to be a delivery why weren't you more prepared? No suction, no sheet spread here, no light switched on. For the twenty minutes that that baby did not cry, the nurses did not care. Then later, after I took the mother and child to the ward and made sure they were all settled in, I ran into another staff nurse. She must have heard from her colleague what happened. She really fought with me. And she threatened me, 'we will put up a banner in the delivery room saying no ASHA allowed here, do not disturb the delivery'. I told her, it was because of my 'disturbance' that the doctor was finally called. The staff had given up. They didn't care. It was an emergency but did they treat it like one? *I was so stressed out. I kept thinking, if this baby dies, what will I do? How will I go back to my village? Everybody will question me. They will ask, Jaspreet you had taken them to the hospital and their baby died there? Did the baby die because you took them there? How will I ever bring this couple back to the hospital for anything? How will anyone ever listen to me again?* (emphasis mine).

[2] Government employment is divided into 4 classes. Class 4 refers to the lowest level of these jobs, such as sweepers, attendants, peons.

Jaspreet's mounting distress in this case is indicative of the responsibility she feels, and the power she does not. Even though she categorically blames the nurses on duty for being negligent, she feels personally implicated in what happens to the child. She is critical in her previous answer of how health department staff put so much responsibility on ASHAs, but here she speaks with the knowledge that she cannot escape responsibility in the eyes of her community. The urgency and anxiety with which Jaspreet responds to the newborn not crying—while the staff nurses are more impersonal—is explained by Jaspreet's proximity to the family. This is the bind of organic accountability that ASHAs find themselves in. It is the flip side of the rewards they accrue from intimate ties with families.

ASHAs *want* to be seen as trustworthy by their communities, but the nature of their work does not always make this possible. ASHAs are bound to "fail" some patient at some time. This does not have to be the ASHA's fault for it to be seen that way. This is most apparent to me with Indresh. Indresh is a new ASHA. When we first meet, she has been in the role only a few months. Indresh is lanky, shy, and speaks so softly you have to lean in to hear her. We become close when I attend a five-day ASHA training, during which I sit by her. When I see her next, it is on the day of a big meeting in the rural block. The block has clubbed several meetings together that day – the ASHAs' monthly meeting, the nurses' monthly meeting, and a family planning workshop. This time too I take a seat by Indresh.

We speak about her children. She shows me photos on her phone. The room is abuzz. Looking around she says she was worried the civil surgeon would be present for this meeting, but he is not. She is terrified of him. Why, I ask. She tells me about a maternal death in her village. A patient of Indresh's was pregnant with her third child. She was supposed to give birth in a government hospital but when she went into labor, everything happened so fast that she ended up

giving birth at home, with the help of a *dai*. The baby, a girl, was fine. The mother, however, lost a lot of blood. They took her to a hospital, but she did not survive. Indresh and her nurse were devastated by this. In cases of maternal death, it is protocol for the civil surgeon to head a review. During the review, Indresh says the civil surgeon spoke to her and her nurse "so badly that on the walk back, my nurse wanted to jump into a canal and kill herself." The nurse couldn't bear to be blamed for the death. She had worked in that area for most of her life. She was popular and respected. But after this case, she requested a transfer out.

Indresh tells me about how this death impacted her. "I was so depressed, my head was full of this. I didn't eat properly for two months." Her eyes well up and she starts dabbing them with her *dupatta*. I hug her sideways, and try to console her. She is sobbing. I am taken aback when Indresh breaks down in the rural block meeting. I know that maternal and infant deaths occur. Their numbers can be brought down, but the risks associated with childbirth, especially in a low resource setting, cannot be eliminated. However, I did not realize the meaning of this for ASHAs until I witnessed Indresh's distress at close quarters. Before Indresh, most ASHAs I was hanging out with had been ASHAs for several years. They would talk about stressors in a matter-of-fact way. With someone new like Indresh, the hurt is raw. It seems like she has not yet learned to suppress, process, or manage her feelings like the others.

A couple of months later, I am in Delhi taking a break from fieldwork when Indresh calls. There has been another maternal death in her village. The woman in question was in the seventh month of her pregnancy. Her hemoglobin was low, and Indresh had been pressing her to come to the hospital for an infusion. But the woman was a day laborer, busy doing work under a government scheme that provides rural employment. She kept postponing her visit to the hospital. On the day she died, Indresh ran into her and reminded her again to make time for a hospital visit.

That night at home, the woman suffered a seizure. She died before she could receive any help.

Indresh tells me she was so disheartened she wanted to quit. But people have been assuaging her, telling her it's not her fault, and she shouldn't feel so sad. Indresh whispers almost inaudibly about the woman who died, "her daughter is in Dilpreet's class." Dilpreet is Indresh's son.

Indresh is now worried sick about the two pregnant women currently under her care. They have both been difficult to follow up with. I tell her to be strong, that these things come with the territory in health provision. "Yes," she agrees, "but everyone doesn't understand that. Some people do. But some people blame the ASHA."

Some weeks after this, Indresh calls again. This time she is worried for her job. A woman from a neighboring village, under another ASHA's care, has died. Indresh tells me this woman was "mentally upset." She delivered a baby by c-section in the government hospital and was discharged. Shortly after she was readmitted because she allegedly tried to open up her stitches at home. At the hospital ward, she "went crazy," hitting other patients and consuming their medicines. She was stitched up and discharged again, but died at home. Because the death occurred in the post-partum period, it will be treated as a maternal death and duly investigated.

This death, whatever the circumstances, has nothing to do with Indresh. But Indresh's nurse has told her that the Medical Officer of the block to which both these villages belong remarked in a meeting, "why are there so many maternal deaths in this block, we should remove the new ASHA (referring to Indresh)." This comment is making Indresh incredibly anxious. She begins to ramble on our call. "Why will they remove me? When the first death happened, I had been an ASHA only three months. I had not received any training. No one told me that even after a home birth you have to take the mother and child to a hospital. Our LHV just wants me out. She wants to put all

the deaths on me so she can replace me with her own candidate. I don't want to be shamed by the civil surgeon again."

Indresh's feelings of distress, sadness, and insecurity are acute. Because she is new, and new to working through these feelings, she articulates them to me often. These articulations offer a window into her emotional interiority. The stress, guilt, and shame that mark this interiority are not unique to Indresh, even though Indresh makes them uniquely visible.

As health workers focused on maternal and infant health, the role of an ASHA exposes women like Indresh to illness, death, human frailty, and suffering. As link workers, ASHAs promote health services that are meant to reduce suffering but, given the under-resourcing in the public sector and profiteering in the private sector, can also *increase* suffering. In my interviews, the more experienced ASHAs recounted how difficult it was, and still is, to manage their feelings. Take Navdeep as an example:

> Me: Do you remember your first visit to the hospital as an ASHA? What was it like?
>
> N: So much tension! My first patient was a high risk case. I had taken her for delivery to the sub-center. She got a referral to the civil hospital. I was so stressed. I didn't know how I would manage, I had never even been to the civil hospital. So I took along the other ASHA from my village, who was older, so she could help me out. Because I had no idea. I didn't know which doctor to take the patient to, where… I knew nothing. So she helped me. The delivery happened. The child needed to be admitted to a children's hospital. We did that. Everything seemed fine at the time. When we got back, the patient was fine. She was discharged the next day. We all went home. As luck would have it, both my children were sick too. The next day I brought them to the hospital and had them admitted. Then I get a phone call from the patient, that her stomach is hurting. So I left my husband with the kids and I went back to the village to see the patient. Her stomach was totally swollen. We put her in a car and brought her to the civil hospital. Here they said her stitches down there had opened, so they stitched her up again, put her on a drip, I don't know what all… But even the next day her stomach was swollen. It didn't set right. Then this hospital referred her. The family took her to a private hospital without telling me. I was with my children at the time. She was in emergency at that hospital for two days. On the third day, she died.
>
> Me: Your first patient…

> N: For three or four days I didn't eat a bite. I cried so, so much. I kept saying, I don't want to do this work. The patient's family blamed me. They said because of you this happened, because of you that happened… I became so terrified. I lost the desire to work. The child, who was struggling, survived but the mother died. I don't know how it happened.
>
> Me: How did you come out of that?
>
> N: Everyone around me, the nurse, the staff, started saying, how is this your fault? So then slowly, slowly I got back into work.
>
> Me: How does it feel when you come to the hospital now?
>
> N: Now I don't feel scared. After so many patients, I have become tough, firm. What is to happen will happen. I try my best for every patient. I go above and beyond what is asked of an ASHA. There is always tension, but the way I see it now, the biggest tension is the doctor's, who has to handle the patient. The ASHA just has to bring the patient to the doctor.

Navdeep remembers the death of her first patient like it was yesterday. Even though the events she is narrating took place ten years ago, there is anguish in her voice. At the time, Navdeep was utterly demoralized, she says. Today, she is "tough." She has compartmentalized her role, rationalized its limits. She is responsible for facilitating treatment she says, not for its outcomes. Even so, "there is always tension."

This climate of "always tension" is commonly commented upon in my interviews. Harminder, who we met earlier in the chapter, has been awarded by the local administration for being the highest earning ASHA in the district. A framed photograph of her being presented with this award has pride of place in her living room. She tells me she handles her patients with affection, no matter how irritated or impatient they get. It doesn't always work though. She shares her experience of an infant death from a few years ago. The themes are familiar – the civil hospital refers a difficult patient to Faridkot, they end up at a private hospital instead, the mother survives but the child does not.

> H: When the child died, the patient took out all her frustration on me. I cried so much when I got home that day. I told my husband, I don't want to do this work, I am quitting. I did

> nothing for a couple of days, absolutely nothing. By then, my other patients started calling me, turning up at home, asking me to go with them. I would tell them to go to the civil hospital on their own. The way that family spoke to me... The child was a grandson of our village. A male baby. You know how bad that feels, male baby. My husband and I went to their house. We spoke to them. My husband especially explained things. Life and death is in god's hands. It is not up to anyone else. He said, she did so much, she accompanied you everywhere, in the middle of the night. It's not like she gave your child an injection and killed your child. But they were stuck on one point-- why did you have to take us to the civil hospital at all? I felt rotten, in my heart. That feeling didn't go away for 10-15 days. Then I slowly got back to work. These kinds of problems keep happening. But even today, I can see that child before my eyes.
> Me: There is so much trauma in this work. Is there anyone you can speak to about your feelings?
> H: No, in this work there is no escape from that. People say a lot when things go wrong. When things go right, then you feel satisfied, you feel at peace. There are so many patients. You have to think about them and just keep going. So many patients who just don't know how to use hospitals, especially during first pregnancies. If you leave your work, what about them? What about their lives, their deaths?

There is no mental health care for women like Harminder. They are exposed to suffering on a routine basis. However, their exposure to suffering is prevented from becoming *routinized* because of their proximity to the families they serve, and because of the blame and guilt that is directed at them. In a sense then, ASHAs are not just witnesses to suffering. They also suffer themselves, along with their patients. However, the Indian public health landscape makes no room for this suffering. Not only have ASHAs been given a liminal status in the health department, the issue of mental health itself is not a priority for state services, least of all the mental health of staff. When a low-ranking issue meets a low-ranking workforce, as Harminder notes, no escape is possible.

Chapter 4: Care work as political socialization

One of the first things that struck me about Muktsar—even before I had figured out my coordinates—was how forthright ASHAs were with me about two things. One, they complained easily and often about how overworked and underpaid they were; and two, they wondered amongst themselves (and asked me) whether the government might make them tenured, salaried employees, as opposed to their present status as volunteers paid per-case incentives. These two conversations stemmed from two palpably different affective modes. The complaining, even when it was done with a light touch, usually felt heavy. The women spoke of being worn down by their work, of feeling overburdened and mistreated. But when they wondered about what might become of them in the future, even if they spoke in disparaging tones about the state, there was a lightness to the conversation, a sense of hope. They were looking to the state with some certainty that the state would, sooner or later, do right by them.

These feelings—of being exploited by the state and being hopeful about the state—seem contradictory. With time though, I realized that ASHAs' hopefulness about the state is neither irrational nor baseless. On the contrary, ASHAs are picking up on a quotidian production of hope by the state. A big part of why women become ASHAs is because they believe the role is, or will become, a *sarkari naukri* (government job). And while this has not happened, the state keeps the promise alive through its plurality and potentiality, experienced in everyday ways by ASHAs. By plurality I mean that the state has vertical and horizontal nodes that can be activated for one's interests. ASHAs learn through their interactions that the state is populated with agents in different positions across different levels of government. To further their interests, sympathetic agents can be enlisted, and unsympathetic ones bypassed. By potentiality I mean the sense of a state that cares; that makes policy overtures to ASHAs in various forms. ASHAs find themselves the explicit

targets of inclusion in state-run schemes, such as health insurance. This makes them believe the state cares about them, and it fuels their hope that the state will eventually give them what they really want, that is, salaried, tenured employment. Taken together, the Indian state is the holder of what I term "promissory capital" for its workers. This capital explains how the state keeps a workforce like the ASHAs in a relation of chronic attachment to it.

In the day-to-day performance of their tasks, ASHAs facilitate much more than health service delivery. ASHAs socialize themselves and their clients in the ways of the state. As women, most of whom have not worked outside home before, ASHAs learn how welfare is provisioned in the state. They learn both, relevant details of welfare schemes, and the "hidden curriculum" of how to secure access to these schemes. ASHAs pass on this knowledge to their communities. This enables community members to partake of welfare schemes, providing crucial 'last-mile connectivity' in a country where large swathes of people are routinely and arbitrarily left out of poverty alleviation schemes intended for them (Gupta). In so doing, ASHAs expand the social rights of citizenship for themselves and the communities they serve. Moreover, there is a recursive relationship between political and social rights. One's ability to expand the social citizenship—especially rights to welfare—of others can open up avenues for the expansion of one's own political participation. For the women in my field, this took the form of participation in the ASHA union, and in local government elections.

SARKARI NAUKRI (GOVERNMENT JOB)

In my interviews with ASHAs, I asked why they had decided to take up this position. The dominant reason was the hope that the post of an ASHA would eventually graduate from that of a remunerated volunteer to a *sarkari naukri* or government job. Here is Jaspreet, a rural ASHA who was appointed in 2008, when the state first recruited this workforce:

> I decided to become an ASHA because I thought somewhere down the road the government will start paying us, they will make us regular someday. This is the hope with which I joined. But this hope will never be fulfilled (laughs). It will stay like this! (shakes her head with a smile).

Jaspreet says she joined with the expectation that the position of an ASHA would, in the foreseeable future, become salaried and tenured, neither of which it is at the moment. Notably, when Jaspreet says that this hope will never be fulfilled, she laughs and shakes her head with a smile. She is articulating a scenario that is disheartening, but her non-verbal mannerism does not convey pessimism. Even as she acknowledges the dashing of her early hopes, she is light-hearted, almost disbelieving of her own words. Later on in the same interview, I ask her what she would advise the government to do to improve the ASHA program.

> The work that we have been given under the ASHA program is very good. We are benefitting people through this work. ASHAs benefit people by working round the clock. My suggestion would be that ASHAs should be paid salaries as a mark of respect. ASHAs should mark attendance daily, and then go to work. If the Punjab government gives the ASHA a salary, then she will be respected in the ministry. Then it will be said that yes, this is also a member of the department. She also receives a salary. Then her conduct, her company will be like that. See all of this comes with money. The way we say, 'so and so has a certain look'. Money is a big part of that look. The government should cast a glance in our direction and consider that we too have children. Tomorrow we can educate our children well, we can educate them further, in good schools. If we are doing so much service for people, then it is the responsibility of the government of think of us too, think of us at least a little. We should receive a salary.

Here Jaspreet is making a case for why ASHAs ought to be salaried. She does this by highlighting the value of the work that ASHAs do, by drawing on the moral force of motherhood and the desire to secure the welfare of children, and even by suggesting that salaried ASHAs mark attendance everyday so the state knows they are not slacking off. Significantly, Jaspreet thinks the government should behave more responsibly towards ASHAs. *She sees the government as capable of responsiblization*. She wants ASHAs to be made salaried members of the health department. This

is the *sarkari naukri* she hopes for. And with it she associates material returns (money), dispositional returns (conduct, look), status gains (respect) and better social ties (company).

Sheenu, an urban ASHA, says she did not know what the post would entail when she joined in 2015. "All we knew was, this is a *sarkari naukri*, so let's fill the form." Sheenu assumed that the ASHA position was a government job as it exists in public imagination, that is, as the pinnacle of stable and respectable employment. When I ask her what has changed for her since becoming an ASHA, she talks about becoming more confident in her interactions with people. She has a lot of knowledge now about child health that she did not have earlier. This is clearly a source of pride for her. What about your family life, I ask, has anything changed there? Sheenu tells me she prefers the flexibility of timings in the ASHA role to the strict hours she kept in her previous job at a private clinic.

> I live by myself, so there is nothing else that has changed. My kids are small, so what will they say. But yes! They show off you know, 'our mother is in *sarkari* (government)!' (laughs). What do they know that their mother is a day laborer!

Sheenu laughs off the bitter reality of her role ('day laborer') that contrasts with her children's rosy image of what their mother does. However, that Sheenu's children 'show off' to others about their mother being 'in government' conveys the high regard in which people still hold government employment.

Harjot, an urban ASHA appointed just three months before I interviewed her, said this when I asked her how her family reacted to her appointment:

> They didn't say anything to me. They said, 'If this is what your heart desires then do it. It's always good to be *sarkari*.' Then I did it. I thought, never mind! No matter what the work is like, somewhere one is *sarkari*. Even someone who is sweeping, cleaning here is sarkari.

Harjot articulates the notion that being *in* government (*sarkari*) is prestigious in and of itself. What one does *for* the government is secondary. It appears from her answer that her family reinforces this view.

Like Harjot, Navjot is a newly appointed ASHA, but in a rural area. She is a widow, and lives with her young son and her in-laws. When I ask what has changed for her since becoming an ASHA, this is what she says:

> It makes a big difference to how you conduct yourself. Because you get that confidence that I am a government servant. I should live like a government servant. There is a big difference between being confined to the house versus stepping out. To have to get ready in the morning and go for duty (laughs). It is very different. When you are at home, anything goes. If you have to wash your hair, you think 'I can do it in the evening, it's not like I have anywhere to be'. Nowadays in the morning I think I have to run, so I wake up early, get ready quickly, leave on time. It gives you a timetable. And you should see how I talk to my son! 'This thing you're doing, do it this way, not like this' (mimics like she is pointing at her son). I instruct my son like I am a doctor!

Like many ASHAs, this is Navjot's first time working outside the home, and here she articulates the difference this has made to her subjectivity. She has a routine now. The authority and the knowledge she derives from being an ASHA allows her to talk to her son, in her words, like she is a doctor. She attributes these changes in her disposition and conduct to her newfound confidence from being a government servant. Navjot is aligning her lifestyle to her notion of how government employees live. In this notion, government employment is associated with authority, dignity, purpose, and hard work. Navjot wants to demonstrate through her ethic that she has these qualities now, and that she is worthy of the government.

Amanpreet, an urban ASHAs, conveys a similar sentiment when I ask her what recommendation she would make to the government:

> We want that we too should have government status. The hospital staff says to us, you have been kept only for service, only as a volunteer. They should not say that to us. It is our desire, our hope, that the government will keep us on as well. We want to be attached to the government.

Amanpreet uses "we" to answer my question. She articulates a collective desire, on behalf of all ASHAs, for government status. Her tone becomes soft and felt, and her choice of words—keep us on, attached—convey an intimacy, affection almost, for the state.

Simran, an older urban ASHA, worked in a private school for over two decades before a nurse convinced her to switch to this role. She tells me, "I have always wanted to work for the government. It is a matter of great pride for me." During the interview, I ask her how her relationships are in her area:

> Like, if someone is having a function for their child, we will be the first people they invite. Some people are nice. They show a lot of respect. We might take a gift for the child. It makes us feel like as ASHAs we are now part of a big family. As ASHAs all of society is related to us. It feels very good. (pauses) But there is one thing. It happened 3-4 days ago in my area. There is a young woman, she doesn't have a mother-in-law, she has two daughters, one is a year and a half old and the other is four months. Her father-in-law beat her up a lot. He really beat her up. And no one from their street went to her aid. When no one intervened, I couldn't take it. I ran to her and made him stop. Then their neighbor said to me, 'in our neighborhood this is allowed, the father-in-law can hit his daughter-in-law'. I said, 'I am a government servant. If I want, I can have this practice stopped in five minutes. Shall I call the police?' Everybody became silent. The father-in-law just picked up his cycle and left for the market. I came away to the hospital after that. I know that the girl's parents have taken her back to their place for now. I could not take it. See, we are *sarkari*. We might not have a salary, but we do have authority.

As an ASHA, Simran feels she is part of an extended family. But she is privy also to the violence of this family. When she intervenes in an episode of domestic violence, she draws on her perceived authority as a government servant. In this instance, her occupational status in the state is less salient than people's perception of her as an agent of the state. She uses this to shut down the beating she witnesses. That she succeeds is evidence of the authority government servants are seen to have.

There is an affective charge to how ASHAs speak about the *sarkari naukri* they desire. Williams' (1977) notion of "structures of feelings" ask us to think of feelings not as individualistic or superfluous but as political and collective. Feelings reflect an understanding of a shared present that is felt before it is known. In my interviews, ASHAs convey this affect not only with what they

say about *sarkari naukri* but also how they say it, that is, with an optimism that belies their circumstances, with lightness and hope, even occasional affection.

Most women become ASHAs with the expectation that this is, or will become, a government job. But what is this government job they speak of? It is primarily notional: a job that used to be salaried and tenured and still is only in public perception, because the reality of the job has changed. The National Health Mission, under which ASHAs are appointed, has only contractual employees, but ASHAs are not even contractual employees: they are remunerated volunteers. ASHAs, then, have attached themselves to an object that has been hollowed out over the years. This attachment nonetheless does some work- it keeps them going. Many ASHAs said to me that now that they are in this role, they cannot leave. One ASHA described it evocatively as something that is stuck in her throat: "Neither can I swallow it, nor can I spit it out." The notion of a *sarkari naukri* exemplifies the pull that states have on public consciousness. Put another way, the state contains promise for ASHAs, or as Bourdieu (Bourdieu, Wacquant, and Farage 1994) might put it, it is the holder of promissory capital. It does not need to fulfil its promise for this capital to work. How, then, is this promissory capital effective? In the next sections, I show that the experience of the state's plurality and potentiality work to boost this promissory capital, to produce and maintain hope in the state.

PLURALITY: MAKING THE EVERYDAY STATE WORK FOR THEM

September 2018 was a dramatic month for the urban ASHAs in my field. I first became privy to this when the ASHAs organized a *dharna* (demonstration) at the office of the civil surgeon, the highest medical official in the district. They demanded action against a woman pharmacist, who got into a row with a patient. Apparently, she asked the patient to refer to her as "sir." And when the patient refused, saying you are madam not sir, she locked the door and began

to hit the patient with a register. Although the incident sounded bizarre to me, I was by then familiar with the pharmacist's reputation for mistreating patients.

This time, though, it was not just about her conduct with patients. The pharmacist also got into a row with an urban ASHA, Jyoti. She remarked to Jyoti something along the lines of, "I know what you ASHAs are like, you sling your purses and go from house to house." This comment implied that ASHAs were sexually licentious women, using their position to get involved with men in different households. The ASHAs were outraged by the insinuation.

The civil surgeon instituted an inquiry into the pharmacist's conduct. I accompanied a small group of ASHAs, including Jyoti and the ASHA union president, to the hospital for the inquiry meeting. Here is my fieldnote from that day:

> We are beckoned into the office of the acting Senior Medical Officer (SMO), in charge of the hospital and the urban block. I squeeze into one of the back rows. The room seats about 12 people. The SMO is sitting at a large table in the front of the room, with a clerk by his side.
>
> The inquiry begins with the SMO asking the pharmacist to leave the room for some time. He addresses the ASHAs, but mostly the two nurse supervisors who are sitting in the front row. The nurses have a litany of complaints about the pharmacist's work and behavior. They claim she terrorizes them; she doesn't even let the sweeper clean any room other than her own. The ASHAs don't say anything. The SMO says, "If this satisfies you people, I will call her back in and tell her this is her last warning, and that if there is any other complaint against her in future, we will take action." The room does not object. He continues, "We are one department, he says. We should live like a family. The work of the state will happen whether you fight or get along. Your salaries will come whether you fight or get along. So, we should not fight. Let's finish this matter here. If word gets out, then outsiders [here he names the press, political parties] they will simply relish our troubles at our expense. There are fights in every family. But families move on and so should we." The nurses nod their assent. They say we just want to do our work in peace. We don't want to deal with her. The pharmacist is summoned back in. The pharmacist immediately starts speaking. Sir, please see my work, I take care of fifty patients a day, I work so hard, but if I have unknowingly made a mistake then I ask you to forgive me. He says to her, "You are in-charge, you must learn to manage people, this is the work of a senior." Now she begins to sob. The SMO puts an end to the matter by dictating a letter— "we have resolved our issues and agreed that there should be no complaints in the future" —which he gets signed by all parties in the room. The SMO concludes the meeting by making the pharmacist shake

hands with the two nurses. He asks them, "Whose birthday is coming up? I want to see pictures of a party with all of you eating samosas!"

The matter with the pharmacist was resolved to the satisfaction of the urban ASHAs. After the meeting, they were visibly pleased. To me, it revealed that the ASHAs were politically savvy about managing their everyday life in the state. They had put their heads together after their various rows with the pharmacist, and decided to escalate the matter through the newly revived district ASHA union. They had known how to secure allies in their fight—both horizontally, enlisting other urban ASHAs, and vertically, by joining hands with their nurse supervisors who were also fed up with the pharmacist. There was also a common bent to how they had narrativized their victimization—saying to other staff, and me, that hardworking ASHAs, going house to house for the government, had to face character assassination just for doing their jobs. They had known exactly how to demonstrate—at the office of the highest medical officer in the district, with a written petition—and exactly when to step back—none of them spoke up in the inquiry meeting, letting the others take the lead. When the SMO, a male doctor, was addressing a room of women nurses and ASHAs far below him in rank, he drew on the metaphor of a quarrelling but ultimately united family. In so doing, he both channeled and embodied the benevolent patriarchy of the state. The ASHAs did not interrupt or challenge this narrative, probably because it was working in their favor. After all, the pharmacist who was trying to show them *their* place was being put in *her* place through the inquiry.

After the meeting, the ASHAs felt vindicated, and said to others who were not present that they had succeeded in showing their strength. This incident was one of many times I observed ASHAs activate different nodes in the state in an attempt to secure their collective, or individual, interests. ASHAs are intimately familiar with the plurality of the state, that is, they know the state has various vertical and horizontal nodes that can be activated. These nodes can be effective against

each other—a senior can override a junior or another senior officer—and can get them what they want—especially when, given their liminal status as "volunteers," matters come down to discretion. ASHAs' attempts to use this plurality to their advantage do not always succeed, but that they try suggests an optimistic engagement with the state.

This was not the only time I observed ASHAs work the plurality of the state to their advantage. Neeta is another example. Neeta is well ensconced in her universe. She has been a rural ASHA for ten years, is well-known and hard-working, and lives with her aunt who is also an ASHA. When I met Neeta, she had just rejoined work after a nine-month hiatus that she was forced into. This was the result of a fight between her, and a newly appointed gynecologist, Dr. Jeet, at the health center where Neeta reports. The fight began because Neeta left for home to attend to a guest without asking or informing Dr. Jeet on a day that Dr. Jeet had called a meeting. So, the next time they met, they fought. Dr. Jeet asked Neeta to get out of her room, and Neeta, incensed at the way she was being spoken to, fought right back. From then on, Dr. Jeet forbade Neeta from setting foot in the health center, effectively putting Neeta out of work. As an ASHA, Neeta could not have her patients serviced, or collect any payments, without using the health center. So Neeta decided to cut her losses, and said sorry to Dr. Jeet. But a verbal apology was not enough; Dr. Jeet wanted a letter. Neeta provided one, but Dr. Jeet did not relent.

Then Neeta sought the help of her sarpanch, that is, the head of the village-level government. The sarpanch met with Dr. Jeet, who told him that she was not going to capitulate so quickly, and that Neeta would have to wait a month or two, as a lesson. But the two months turned into five and then six, and Neeta's situation did not change.

After thinking long and hard about her problem, Neeta decided her best shot was one Dr. Sandeep. Dr. Sandeep runs a private hospital-*cum*-medical college in the district. The medical

college is functional and students attend, but the hospital runs only in name. When the medical board sends an inspection team to the hospital, Dr. Sandeep puts on a show for them. He hires some ASHAs on a daily rate, and trains them to pretend to be hospital staff. He also hires fake patients, and makes out fake slips with diagnoses and prescriptions. Neeta has been part of Dr. Sandeep's fly-by-night operations for many months. She has his number on her mobile. Dr. Sandeep's brother is married to Dr. Rani, who is the Senior Medical Officer of Neeta's block, that is, the highest medical authority for that area. Dr. Rani, then, is Dr. Jeet's boss.

This is the node in her network that Neeta decides to activate. She consults with Preeti, also a rural ASHA and now on the union, and they come up with a plan. Neeta makes some phone calls, and lands up at Dr. Rani's home to speak with her. Dr. Rani is a kind-hearted and conscientious administrator. In my expeirence she is well respected by all levels of staff. Finally, it is Dr. Rani who intervenes on Neeta's behalf. She persuades Dr. Jeet, and Neeta is reinstated.
To be clear, there is an official process for the removal of an ASHA who is deemed to be "non-performing." If, on the basis of her incentive payouts, she is determined to not be working, and there is no explanation provided by her, then after three months she can be dismissed and another ASHA appointed in her place. This process was neither applicable to nor followed in Neeta's case. Neeta's problem was one of an intra-bureaucratic conflict, brought on and later resolved entirely in an affective and informal register. What is more, Neeta realized the character of her conflict. That it would take something other than simply complaining about Dr. Jeet to higher authorities. It would take, for want of a better term, a 'personal touch.' A node that was both senior to Dr. Jeet, but also felt affectively involved on Neeta's behalf.

For ASHAs then, the state is a mixed bag. By enabling gratifying experiences while remaining "fragmentary, local, personalized, and frequently unsatisfactory" (Li 1999), the state

keeps them hopeful. The satisfactory experiences not only make ASHAs temporarily upbeat, they also serve to blunt the edge from *un*satisfactory experiences. This dynamic character is part of how the state's promissory capital is bolstered and sustained.

Another part of how promissory capital is upheld is not only through what the state *is*, but also through what the state *does*. In the next section, I show how the Indian state makes active overtures to ASHAs.

POTENTIALITY: STATIST OVERTURES TO ASHAS

It is the last day of a five-day ASHA training on maternal and newborn health and nutrition. This training is being attended by 40 ASHAs, most of them recent appointees. It is just after lunch now. As the room settles back in, some ASHAs ask one of the lead trainers, Amarjot sir, about a public announcement made a couple of days ago. During a televised address on September 11th 2018, Prime Minister Modi announced a "Diwali" or Hindu new year gift for ASHAs and other frontline workers. Modi said that starting October 2018, ASHAs will receive a hike in some of their monthly incentives. These are incentives for routine activities and they are paid out from the center's budget. ASHAs will also be eligible for insurance cover under two central government schemes. Amarjot sir is asked for more details about this announcement. He confirms to the room, "Your routine incentives will double and you will get free insurance." He adds with a nod, "Elections are around the corner, Modi wants votes, so he will definitely do something."

The room is immediately abuzz with conversation. "But look how much more Haryana is doing!" say some, referencing the neighboring state that has given its ASHAs a fixed monthly pay, in addition to case-based incentives. Others say, "They always keep us hanging, let's see if the money actually comes through." Here Sukhdev, the other lead trainer, jumps in. He holds up one

hand and assures them, “If the government has put it in the newspapers, then they will definitely do something.”

The remainder of the afternoon goes by in discussing acute respiratory infections. When the trainers declare they are done for the day, some ASHAs bring up the Modi announcement again. This time Sukhdev explains,

> Modi did video-conferencing with ASHAs before this announcement. The ASHAs of *Barnala* [another district in Punjab] participated. The new incentives will come through, we just don’t know when. You people remember, when the government announced it would give a Rs. 6000 [USD 85] cash transfer to mothers for their first born, we all thought, how will it happen, it is so much money! But now see. It is happening right? Be patient.

This training exemplifies a statist production of hope. There is active political socialization at play here, and I argue that it results from the state’s message but also from the messengers, in this case the lead trainers Amarjot sir and Sukhdev.

The announcement by the central government in the run up to a national election is an overture to India’s frontline women workers. Without acceding to the key demand that their unions have repeatedly agitated for—that of regularized, salaried employment—the PM announces a “Diwali gift.” It is a small concession, but one that is meant to indicate that the state cares, that it is thinking about ASHAs. It also distracts from the big ask, deferring it by generating hope that the state might make more such piecemeal moves, maybe even accept the big ask in due course.

When some ASHAs express dissatisfaction and doubt about these new incentives, they are assured by the trainers that the state will keep its word. Here the ASHAs are being asked by senior officials—agents in the state who lay claim to superior knowledge of the state—to repose faith in the state. The message, put in so many words by Sukhdev, is to be patient. When ASHAs bring up unkept promises by the state, Sukhdev does not argue with this but instead turns their attention to still other promises that *were* kept by the state, in this case a cash transfer to mothers for their first-

born. What the ASHAs bring up directly concerns their low and itinerant pay. What Sukhdev wants them to consider is not even about them but about a maternal and child health policy. However, the point of this rhetorical move is to represent the state as also keeping its word.

Of note is also the kinds of state representatives these trainers are. Sukhdev and Amarjot sir both have a gentle, encouraging manner. They are patient and supportive, and Amarjot sir is held in especially high regard by ASHAs because of his helpful and accommodating nature. As trainers, Sukhdev and Amarjot sir have been taught during their Training of Trainers (ToTs) to be approachable. Sukhdev once told me that he consciously uses self-deprecating humor to put ASHAs at ease in trainings. ASHAs experience the everyday state through the approachability of officials like Amarjot sir and Sukhdev, who they frequently interact with and who translate state policies for them.

This matters very much for ASHAs like Babbi. Before becoming an ASHA in 2008, Babbi had studied up till the eighth grade. Since then, she has completed tenth, twelfth, and recently the Auxiliary Nurse Midwife (ANM) course, hoping to become a nurse supervisor. During her interview, Babbi kept saying to me, the *"asha"* lives in *"nir-asha,"* playing on the Hindi words for hope and disappointment respectively. But going over her interview later, I realized it conveyed more hope than disappointment, particularly this excerpt:

> I have come to know myself through this role of an ASHA. I have realized my potential. You know when we had the ASHA training in our block for newborn care, our trainers Dr. Simran and Amarjot sir, they asked me to do a demonstration for the room, of how to blanket wrap a newborn baby. When I did it, they made all the girls clap for me. They said about me, 'This girl has a lot of confidence, she will do something big.' The other girls asked, 'Why are you saying this?' Then Amarjot sir told the room about this one time the health department staff visited our village on immunization day. I did not even remember this. He said the ANM and I were present, and the civil surgeon was visiting. The civil surgeon asked the ANM some questions, and she couldn't answer, she began to tremble. Amarjot sir said about me, 'This ASHA answered all four questions!' That's when they thought, this girl can do a lot. So you see madam this is the faith I have in myself now.

Babbi's sense of self has been elevated since becoming an ASHA. Of note here is what Babbi cites as the source of her confidence, and how she decides to channel that confidence. The trainers who applaud her, who single her out for praise and encouragement, confirm her sense of her intelligence. By bringing up her interaction with the civil surgeon in a training, where she answered questions her nurse supervisor could not, they infuse that interaction with meaning. So, when Babbi says to me, this is the faith I have in myself, it is a faith that is validated by an entity no less than the state. And by dint of that faith, she has studied further, up to the Auxiliary Nurse Midwife (ANM) course.

This is significant. ANMs are the nurses who directly supervise ASHAs. The ASHA program has an in-built pathway for career advancement. There is a quota for ASHAs who meet certain criteria (earning incentives above a certain amount, a minimum number of years in the role, educated till the 12^{th} grade etc.) to enroll in an ANM course at a government institute at no cost. Once an ASHA completes this course (these courses are available in private colleges too), and if the government announces vacancies for ANMs, and if the ASHA is under 35 years of age at the time, then she can become an ANM. Babbi, like several other more qualified and driven ASHAs, has decided to take this pathway. However, although several ASHAs try, in my field site not a single ASHA till date has succeeded in becoming an ANM. Babbi must know this, but it does not stop her.

The ANM pathway then, much like Modi's announcement, produces hope without keeping the bigger promise. And yet, both these pathways convey potentiality, that is, the sense that the state is on your side because it is giving you *some* of what you want. These encouraging maneuvers perform the function of holding ASHAs in the sway of the state. These are active overtures by the state. They produce hope, and through hope they bolster attachment. The attachment does the work

of both, keeping ASHAs in place, and papering over the ways in which the state does not meet its promise. Put differently, the state's promissory capital signifies generalized promise in the state, while de-emphasizing the specific promise that is not yet delivered.

EXPANDING SOCIAL CITIZENSHIP

As ASHAs, women learn the ropes of public life. They learn not only how to use a hospital, but also how public services are provisioned, the hierarchy of officers in related government department, and who to approach for what.

Jaspreet is a Dalit ASHA. She is one of two ASHAs in her village. For ten years she was the only ASHA, till the population grew and another was appointed in 2018. Jaspreet has an air of quiet dignity. When she speaks, she is commanding and articulate. It is hard for me to imagine her any differently. But she tells me she has come a long way. In our interview, I ask Jaspreet about her relationship to state services before becoming an ASHA.

Me: Before becoming an ASHA, would you go to hospitals often?

J: For my own medicines, for the birth of my children, for my children's treatments.

Me: Did you go alone, or with someone?

J: Never alone. My husband would take me.

Me: After becoming an ASHA, now how often do you go to hospitals?

J: Sometimes I make two rounds in the same day, sometimes I stay two nights at a stretch. The hospital has become home (laughs)!

Me: Before becoming an ASHA, did you know any government officers?

J: No. I was limited in my interactions to schoolteachers, not more than that.

Me: Now how many do you know?

J: Nooowww… [stretches the word]. Everyone from the hospital. SMO (Senior Medical Officer), CMO (Chief Medical Officer), the doctors, the district staff, the hospital staff, the ANMs, the staff nurses. Everyone! Total!

Me: [I laugh] Before becoming an ASHA, did you do any public service work, like helping people with ration cards, bank accounts, old-age pensions etc.?

J: No, I had not done any of this work before.

Me: Now do you do it?

J: Now we do all of it. If someone needs an Aadhaar (national ID) card made for their child, we tell them you first need a birth certificate, then you have to go to the services center where they will give you the Aadhaar card, only then can your child enroll in school. Even for ration cards, when someone needs to add a name to their ration card we tell them how to go about it. We tell them, if your ration card has only the husband and wife's names on it, then only the two of you will get free medical treatment under the Bhagat Puran scheme. But if you add your children's names, up to five people per household are eligible for treatment.

Me: So people in your village come to you for these things?

J: Yes, they come a lot. Well, not a lot, but the ones who don't know come. And then we tell them how to do these things.

Jaspreet's answers are typical of other ASHAs in my sample. ASHAs report familiarity with health department staff—from their immediate supervisors all the way up the pecking order to the civil surgeon, the highest medical authority in the district. Some are also familiar with government officers outside the health department, like in the district administration. All of this stands in marked contrast to before they became ASHAs.

Significantly, Jaspreet explains how she directs community members who approach her to welfare services. For example, she tells them how to get Aadhaar cards made. Aadhaar is India's new national biometric identification system. Despite being mired in controversy over privacy concerns, many government offices now require people to present the Aadhaar card before they can avail of services. Because the card is new and is being mandated in this manner, Jaspreet's ability to guide her community to obtain it is a vital service. The other card she mentions, the ration

card, is an older program, in which eligible households can purchase subsidized food grain from the Public Distribution System. Here Jaspreet explains how she directs people to upgrade their ration cards—which also serve as identity documents—so they can avail of another state scheme, Punjab's Bhagat Puran initiative, a cashless health insurance program for low SES families.[1]

Jaspreet is able to connect her community with a range of welfare programs, old and new. She shares her knowledge of the process, step-by-step, including what the benefits of a program are, what is required to enroll in the program, and where to enroll. Other ASHAs told me they did the same. Sometimes, they even accompanied community members, like the elderly, to secure these services.

However, formal knowledge about eligibility criteria, documents required, office addresses, etc. is not enough to access services. Citizens must have informal knowledge about how to navigate the state in real time. It takes a certain disposition to become serviceable by the state. I found ASHAs also teach their communities this disposition.

On a muggy September afternoon, I accompany Kamla as she visits the homes in the neighborhood assigned to her. Much of what she does is what I see other ASHAs do as well: updating household records with the names and ages of family members, informing mothers about the vaccination schedule for children who are due, handing out supplies—deworming tablets, condoms, and oral rehydration solution packets—and advising people on which doctor to consult for which problem. These are Kamla's core responsibilities as a community health worker.

Like Jaspreet, Kamla also informs her community about welfare schemes they do not know about, including educating them about how to access these schemes. In one home, Kamla is introduced to two newly wed women, a pair of sisters who have married a pair of brothers. Kamla

[1] Bhagat Puran covers farmers and construction workers among others, for hospitalization, disability, and accidental death.

notes down their details in her household register. She asks if they have had the address on their Aadhaar cards changed from their natal to marital home. They have not. She tells them to have it done. They don't know how. She tells them which signatures they will need and where to get them. She explains, you will get Rs. 5000 for the birth of your first child if your Aadhaar is updated.

Of particular interest to me is how Kamla translates the culture of the health department for her community. The following excerpt from my fieldnote for that day exemplifies one such interaction:

> The next house we enter has a courtyard. Two young women are washing clothes to one side of it. Kamla asks them about another woman, a daughter-in-law with a newborn. She has gone to her *peke* (natal home) for *rakhdi* (a festival). Kamla approaches the adjacent room. She seems to know her way around. Here, the mother-in-law is napping, but she sits up and asks us in when Kamla greets her. She calls out for three cups of tea, and fixes her henna-red hair that is sprouting a new layer of gray. She and Kamla have a spirited exchange. The mother-in-law is upset with her experience of the hospital birth. It seems the daughter-in-law went into labor sooner than expected. The family rushed to the civil hospital, but by the time Kamla got there an emergency c-section surgery was underway. After the baby was born, the mother-in-law reminded Kamla that they wanted the daughter-in-law's tubes tied, but it was too late. She was already stitched up. Kamla explains, "I didn't want to interfere while the surgery was going on, if something went wrong you would have blamed me!" Kamla turns to me, "the important thing is it all went well, she had a grandson, the daughter-in-law was fine. But she was so upset she wouldn't hold the baby when they brought him out!" Kamla addresses the mother-in-law again, "now do you hold him?" The mother-in-law preens, "now he doesn't let go of me! Even in his *nanke* (maternal grandparents' home) he is searching for me!" Kamla tells her the baby needs to be brought again for his vaccinations. "No," the mother-in-law objects, looking upset again, "no one cares about you in that hospital. They were so rude to me." Kamla explains, "It's not that. The day you came there was a big meeting in the hospital, everyone was just busy and stressed. It won't be that way every time. And I will take you straight to Dr. Rana, she is very nice, you'll see. Five fingers of the hand are not the same, right? You must come." The mother-in-law purses her lips but says nothing. We are done with tea and take her leave. Kamla and she hug.

Here, Kamla is confronted with a client who had a negative experience with the state and does not want to return for more services. Kamla puts the experience in perspective for her. She explains that it was the result of external factors and that there are also "nice" doctors in the hospital. In essence, Kamla is asking the woman not to extrapolate and be deterred based on one encounter.

This is an important lesson in political socialization. What Kamla is really teaching the mother-in-law is that outcomes in the state can be arbitrary (Gupta 2012), but there is also plurality in the state that should give one hope. The confluence of factors influencing an encounter in the state can change, including state agents, of whom there are many, and many types. The significance of this lesson for people who can benefit from welfare services but are put off by its provisioning cannot be understated.

This was a recurrent theme. Many ASHAs told me that people need to be persuaded to give public hospitals a chance. What ASHAs do, then, is akin to a re-branding of the government. I explore the motivational labor it takes to do this in the second chapter. ASHAs say, as I saw Kamla say often on this day, "the public hospital is not like before, nowadays they do tests and treatments very well, and it's all free. The government is good now. You must come."

Indeed, Kamla went beyond a superficial pitch for government services. When asking pregnant women to come to the hospital, she gave these instructions: "Come early. Finish all your chores for the day and leave home quickly. And remember to eat before you come. It can take time. You don't want it to be a wasted trip." This is the hidden curriculum of how to use the public hospital. To expect to wait, and to plan for it, can make all the difference between receiving the service you came to the hospital for, and turning back without it. That ASHAs share this "hidden curriculum" (Apple 2018) keeps patients connected to welfare services.

EXPANDING POLITICAL CITIZENSHIP

There is a recursive relationship between political and social citizenship. One's ability to expand the social citizenship of others can open up avenues for the expansion of one's own political participation. For the women in my field, this took the form of participation in the ASHA union, and in local government elections.

A new set of office bearers were appointed to the Muktsar ASHA union early in my fieldwork. This was part of a revival of ASHA organizing in the district. The union as a body existed previously but had fallen dormant. I interviewed Joginder and Preeti, two union leaders, about their experiences.

Joginder tells me it is the respect and recognition she accrued from her paid care work that propelled her into a leadership role. She enjoys her stint as a union leader. Next, she has her eyes set on a career in politics. Her confidence is palpable:

> I am not small. The government has appointed me. The government has given me a post. I have earned respect at home and outside. Before I was an ASHA, no one in my village really knew me. I was like any other daughter-in-law. Even my family did not think much of me. Now, they consult me for everything. I have convinced my husband to let our two children go to college. After the tenth grade, he wanted to marry them off. I told him, look at my life. I only studied till tenth grade but I made some progress. If they study more, they will make more progress.

When I ask Joginder if she plans to contest elections, she smiles. "Let's see. I don't know. But yes, as an ASHA nothing is difficult." Through her post as an ASHA, Joginder's image of herself changes from "any other daughter-in-law" to someone of significance in her family and her village.

During my interview with Preeti, I ask her what she thinks is the best part of being an ASHA:

> P: I have become a union leader [throws up her hands and laughs]! If any of the girls has a problem, I can help. See, I tell my girls, I tell all the ASHA workers, you must not be at fault. If you are at fault, I will not support you. But if you are not at fault, then I will stand with you. I will stand with you anytime, anywhere, against anyone. And I have stood with them.
>
> Me: It feels good?
>
> P: It feels very good! These are my sisters. If I can stand with them through their troubles, show solidarity, then that means a lot to them. And to me. They give me their blessings. I like doing work that brings me so much appreciation.

I see this play out over several months. Perhaps because the union is fresh into their term, they begin to do a lot. Preeti and her fellow union members hold meeting after meeting in the district. They collaborate with the ASHA union from the neighboring district to participate in state-wide protests. I attend two such protests. Each time, Preeti organizes the transport to and from the protest. She leads the union's effort to put word out among the ASHAs to attend, and to pay their membership dues irrespective of attendance.

I am having *chai* one November afternoon in a private pathology lab outside the civil hospital. This is where Preeti usually hangs out, with a couple of friends in tow. This afternoon there are three ASHAs present, animatedly discussing a non-communicable disease survey that they have been asked to conduct. The group is skeptical of these one-time campaign activities they are asked to do. In the recent past, ASHAs have been pulled into other such campaigns, like administering the Measles-Rubella vaccination, with the promise of incentives that have still not been paid out in full. Now with the non-communicable disease survey, they have to *both* pay out of pocket to make copies of the survey form, *and* administer the survey in every household, but they cannot be sure that they will be paid the incentives due to them when the campaign is over. The group decides they must seek assurance from the civil surgeon's office. I am trying to follow the exchange without interrupting, when Jaspreet, a rural ASHA, walks in and sits down. Her ANM, a young woman called Pooja, follows close behind. Jaspreet has made a strong impression on me in the past. She is articulate, dignified, and even-tempered. Today, however, she is seething.

Jaspreet has been the only ASHA for her village, which has a population of 1700, since her appointment in 2007. In the past, her ANMs have refused to appoint another ASHA. This time though an application to appoint another ASHA in Jaspreet's village has been approved. The woman in question is a widow, and was advised to apply by two other ASHAs--also widowed--

from the same block of villages. Jaspreet is particularly hurt by this. She sees this as a betrayal by friends she considered close. “I have been stabbed in the back,” she says repeatedly.

The new appointment will leave Jaspreet with a population of 1000. Everyone agrees this is outrageous and unfair. Jaspreet declares she will not share her registers with the new ASHA. Wagging her finger she declares, “if she takes a single case from my area, just watch, I will fight with her, I will not take it lying down, I will keep fighting.”

Preeti has an idea. She tells Jaspreet’s ANM Pooja, *“*you take it from this new ASHA in writing that she will only service the population above 1500. So she will only have 200 under her.” Pooja agrees, although I don’t know how doable this is. She tries to placate Jaspreet some more, and then leaves for home. The rest decide to go see Sukhdev, the district ASHA coordinator. We pile onto two scooters and head off.

At the civil surgeon’s office, a short ride away, the group of us walks right into the training room, where Amarjot sir is in the middle of a session with ASHAs from another block. Jaspreet by now is subdued, her body language slumped. By contrast Preeti is energized. She addresses both Amarjot sir, and the other ASHAs whom they have interrupted. She rattles off a list of their concerns, explaining why they have come. She does this with humor, drawing in the room, speaking with confidence and respect. People are nodding and smiling, including Amarjot sir.

Soon Sukhdev arrives. He first dismisses the trainees since it is past 3 PM. Then, Preeti does most of the talking. They first discuss the non-communicable disease form. Sukhdev explains what went wrong with the Measles-Rubella vaccination payment (the health department ended up conducting more sessions than they had planned, so payments were underestimated). Then they come to Jaspreet’s situation. Sukhdev says, “From my position, I can only advise you within the

rules. The guidelines say once the population of a village crosses 1500, another ASHA can be appointed. To your point, yes, she can have the area above 1500, that is possible."

"And if she protests later that she isn't making any money," asks Jaspreet. Sukhdev explains the new ASHA will still make the minimum 1500 or so per month that all ASHAs make for maintaining registers, and other such work. He again emphasizes that because the guidelines ask for one ASHA for a population of 1000, nothing untoward is happening here. He tells them he will try his best to work out a resolution. But he asks them to be understanding. In the past an ASHA he was helping out with a similar issue decided to take her case to court, and named him, Sukhdev, as one of the parties in her complaint. "Now wasn't that wrong of her," he asks. They agree it was. Before we leave, bringing the day to a close, Jaspreet repeats once again that she will have the new ASHA give in writing that she will only work with the population beyond 1500. Preeti, standing next to her, nods her vehement approval.

Jaspreet is not in a position to prevent the new appointment. So, she tries to do the next best thing, that is, save the biggest piece of the area pie for herself. Her feelings of disappointment and frustration are strong, but they do not cloud her strategy. Like Preeti suggests, Jaspreet seeks a written assurance. The centrality of documentation to bureaucratic activity is a constitutive modality of state power in India. As Aradhana Sharma (2008) notes, marginalized women learn this when they become encumbered in the everyday life of the state. They too begin to use paper trails. These might not result in their demands being met, but the paper trails allow them to demand accountability from state actors. Of note also is Preeti's surefootedness in her interactions with Sukhdev and Amarjot sir. Preeti fills the role of a union leader with skill and ease.

Not everyone is comfortable working with Preeti though. Many frown upon her personal life. Preeti left her marital home in the village after her marriage broke down, and now lives in the

city. She continues to be an ASHA for her marital village though. The commute from the city is a short 15 minutes on the two-wheeler she drives. During my time in the field, I see Preeti meet with health department staff on behalf of several ASHAs. Sometimes it is over payment delays, sometimes over unfair dismissals. Her efforts do not always yield the results the ASHAs seek, but she is a steadfast advocate for their interests. A refrain I hear often from the ASHAs she helps is "Preeti really stood by me." As Preeti notes in her interview, her efforts mean a lot to other ASHAs *and to her*. During the latter part of my fieldwork, Preeti's nurse supervisor took issue with her after a patient from her village suffered health complications. The nurse blamed Preeti and wanted her out. She insisted that Preeti could not properly cater to the health needs of her village, living away as she did in the city. This matter is brought before the Senior Medical Officer (SMO) of the rural block to which Preeti belongs. The SMO dismisses the matter quickly, saying about Preeti, "How can they say she is not active, she is very active, I have seen how she works for herself and for other ASHAs."

CONTESTING LOCAL GOVERNMENT ELECTIONS

On a chilly winter morning in January 2019, I am attending a refresher training for rural ASHAs. The morning session has just begun when one of the 30-odd ASHAs in the room stands up abruptly. She announces rather shyly that she has been elected to her village council, the panchayat, and would like the trainer's permission to pass a box of sweets around the room. The trainer exclaims, "oh wow, very good," and the room bursts into applause. She quickly takes her seat. There is conversation about the recently concluded elections to the local self-government. The women in the room discuss other ASHAs they know who contested, confirming for each other who won and who did not, wondering about some others they do not have word on. In this block

of approximately 160 ASHAs, the room counts ten who contested. More names come up for who might contest in future rounds.

As I bite into a *barfi* from the box I am handed, I chat with the ASHA on my right. She points to an ASHA sitting behind us and says, "Lakhvir contested." Lakhir is youthful looking, with a booming voice that belies her slight build. She smiles easily, showing off a set of pearly teeth. When I interview her, Lakhvir tells me she always wanted a job. It was her childhood dream to join the police, but her brother would not allow it. After marriage, her father-in-law pushed her to take the tenth-grade exam. When recruitments to the post of ASHA were first announced in 2008, her nurse supervisor approached her mother-in-law. They had grown up together. The nurse was clear she wanted an ASHA from an SC family because "general category can't do this work, it's too tough." Lakhvir's husband was not in favor of her joining as an ASHA. "He fought with me a lot! He used to beat me. But the nurse told me to persist. She said he will fall in line when you start earning. And that is what happened."

Lakhvir starts crying as she recounts this to me. Wiping her eyes with her *dupatta,* she says, "I have struggled a lot in my life. I managed to get 300 votes in this election, without putting in any money." Lakhvir's supervisors were unclear if a rule disallowing government employees from contesting panchayat elections would apply to her. As an ASHA, Lakhvir is a volunteer and not an employee, so she can legally contest. Despite the confusion, she says, "no one in my village complained, no one filed a case against me for contesting. It tells you that they are with me." She adds, "I would not have contested if I wasn't an ASHA. And if it wasn't a woman SC seat this time." Lakhvir is clearly proud of herself.

> My sisters-in-law tell me, 'you do so much, even our daughters-in-law don't work so hard, don't your legs hurt?' I say no (clicks her tongue). Now I get ready, go to work. I know about government services. I attend trainings. I know how the world works. The women who stay home, what do they know? I can read blood pressure, I know what to do when a

> child is sick. These things may not be a big deal to everyone, but they matter to me. I am glad I didn't stay home, with a long *palla* (veil) over my face like my husband wanted. I am glad I told him, I won't dress in your full sleeves and sober colors!

She is pealing with laughter, flashing her toothy smile again.

It is significant that Lakhvir's decision to contest panchayat elections had to do in part with being an ASHA, and in part with her ward[2] being reserved for a woman SC candidate in this round. The Indian constitution reserves 33 percent seats at all levels of government for Scheduled Castes and Scheduled Tribes, historically marginalized caste and indigenous groups respectively. In 1993, the constitution introduced a system of local governance called Panchayati Raj, which in addition to the SC/ST quota, had a quota for women: at least 33 percent seats at the local level of government would be reserved for women. Higher levels of government do not reserve seats for women. As a result, the two quotas—women's and SCs/STs—come together in local government as a tandem quota. Tandem quota is a system of reservation in which gender and minority quotas exist together (Hughes 2011). In India, this means that within seats reserved for SCs/STs at the local level, at least 33 percent are reserved for women from these communities.

Another ASHA I interviewed, Baljeet, who won the election, gave me the same reason for why she stood for panchayat member: as an ASHA she feels connected to people, and her ward was reserved for a woman SC candidate. Baljeet has been a rural ASHA since 2008, before which she was a trained birth attendant. As a trained birth attendant, she would charge people for her services, but since becoming an ASHA, she links people to governmental services for free. "This has made them more connected to me," she says. She tells me during her interview that people around her wanted her to contest for sarpanch (village head) instead of member.

[2] A ward is the territorial unit/constituency from which elections to local government (panchayats in rural areas and municipal councils in urban areas) take place. In advance of the election date, lots are drawn to pick the wards that will be reserved for women. These wards rotate every election.

> I said no, that is too much work for me to take on. I have work at home, then as an ASHA, and to be a sarpanch on top of that! No, not *sarpanch* (village government head). Member I can do. My husband helps me out with the work too, so that makes it easier for me. Although, if I had contested for the post of sarpanch, as an ASHA, I can tell you the whole village would have voted for me.

India's tandem quotas in local government provide the necessary political infrastructure for ASHAs like Lakhvir and Baljeet to participate in formal politics by contesting local government elections. This is in line with the evidence that tandem quotas—unique to minority women—dramatically increase minority women's legislative representation[3] (Hughes 2011). This is in contrast to gender quotas and minority quotas as standalone, separate policies, which benefit primarily majority women and minority men respectively while keeping minority women's representation low.

And so, I find caste matters not only as ascriptive identity, and the reworking of that into acquired skills and capital, but also as *infrastructure*. SC communities are most likely to use public health infrastructure, compared to non-SC communities. It is in SC communities that ASHAs are able to pass on what they have learnt about the state, and it is here that these lessons are the most meaningful. This is because structural caste inequality takes the form of a public/private sector divide in health (and education). Upper caste and class populations opt out of public hospitals (and schools) and instead pay much greater sums for private hospitals believed to be of better quality. As the ASHAs in my study point out, it is the poor and SC households that most benefit from

[3] Given the limited number of seats in government, quotas designed to expand the representation of one marginalized group often come at the expense of another marginalized group, rather than majority men. Tandem quotas most directly and effectively counter this. By carving a space for minority women that acknowledges the intersection of their identities as minority *and* women, tandem quotas is the policy that takes the largest share of seats from majority men.

public services[4]. This is borne out by recent quantitative analysis of the ASHA program[5]. And SC ASHAs, because they become prominent women in their communities, are likely to use tandem quotas in the local government infrastructure. As Baljeet and Lakhvir's arcs show, SC women as ASHAs gain confidence from being connected to so many people in their village. They are convinced of people's support. This conviction is a necessary but not a sufficient condition to contest elections. Ultimately, it is the combination of their confidence in how they have connected with people as ASHAs, as well as the fact that tandem quotas give them a pathway into office, that tips them over into actually contesting elections.

[4] To be clear, this does not mean marginalized communities would automatically use public services out of need. On the contrary, out of pocket expenditure on health in India is remarkably high. Marginalized communities can save time and avoid the humiliation and confusion that often comes with public hospitals by opting for private health care. It is the ASHA who acts as their guide, smoothening the experience of public health care for them.

[5] Based on nationally representative survey data, Agarwal et al find that in areas where active ASHA activity was reported, the poorest women, and women belonging to scheduled castes and other backward castes, had the highest odds of receiving ASHA services.

Chapter 5: Who's afraid of the private sector?

On September 14th, 2019 my WhatsApp pings with messages from Sakshi aunty. Sakshi aunty is my cousin's mother-in-law, who I lived with in Muktsar during my fieldwork. One could say we are close. It's the sort of closeness brought on by both circumstance and deference to family norm. I think we both know this, and don't mind it. At this point, I have been in Austin post-fieldwork for nearly three months, about the same length of time since I last spoke to Sakshi aunty. I see that her messages consist of multiple forwards: a video and several texts.

The video is of the civil surgeon[1] from Fazilka, the district adjoining Muktsar. He is speaking at a press conference. He begins by explaining that he was on a round of the hospital that morning, checking on and meeting with staff. This included ASHAs, against whom he says he has been receiving many complaints. ASHAs were appointed to care for patients, to bring them to government hospitals, he explains. But ASHAs now use any small or big limitation of the public sector to mislead patients and re-route them to private hospitals that give ASHAs commission. This is leading to unnecessary ultrasounds, feticide, and so on, he says. It seems, at the staff meeting that morning, he took this up with the ASHAs who were present. He told them that the private sector, with its unaffordable prices and questionable quality of care, must be a no-go when free and reliable governmental health care services are available for patients in need.

Upon leaving this meeting, the ASHAs began demonstrating outside the hospital against the civil surgeon. They accused him of insulting them with abusive language. The civil surgeon forcefully denies this allegation in the video. He insists there was no, pardon my pun, uncivil conduct from him. In fact, he goes on, he has never been accused of anything like this in his 33

[1] The highest medical authority in a district, usually a government doctor close to retirement.

years of service. Other staff present at the meeting can bear out his account of the day's events. He asks the Punjab government to conduct an inquiry into this incident.

Then, he accuses ASHAs of looting people to line their pockets, of badmouthing the public sector, and promoting the private sector. He asks the government to reconsider their appointment. It is his experience, he says, that Punjab unlike other states, that are so much worse off with poor roadways etc., does not need ASHAs. In response to another question, he confirms that the protesting ASHAs did not let his car pass that day; he implores the administration to tackle the persisting menace of violence against doctors. He adds that since his office--the office of the civil surgeon-- appoints ASHAs, he himself should be charged with the inquiry against the protesting ASHAs as well as the authority to dismiss them. He claims his staff are saying that ASHAs are not even staff members but look at the ruckus they are creating outside, threatening to shut down the delivery (birthing) room. Is this the kind of employee the Punjab government wants?

In this chapter, I attend to this question that Fazilka's civil surgeon raises. What kind of employee does the Punjab government want in the ASHAs? Or to put it in descriptive rather than normative terms, what kind of employee has the government created in the ASHAs? I tackle the particular issue of ASHAs' private sector links, what it means for ASHAs, and what it reveals about the relationship between the public and private sectors.

For now, it's back to Sakshi aunty's WhatsApp messages. Sakshi aunty used to be a gynecologist but no longer practices. She and her husband, an ophthalmologist, now run an eye hospital. The texts she shares with me are from a WhatsApp group of a close circle of doctors in Muktsar. I include verbatim two excerpts here:

> "This is the first time we have heard someone finally speaking the truth about Asha's.. The CS deserves full appreciation and support from all quarters..esp d Gynae/Obs groups. The scourge of Ashas has assumed demonic proportions. Not only do they pick up preterm deliveries but misguide pts as well. Known as 50% they can go to any extent for their

> commission. Even the newborn is taken to d paediatrician for commission purposes. Getting unwanted scans and Cesareans..these unbaked nurses play havoc with d mothers life..nd have caused increased maternal mortality. A new trend is of Ashas bring medicine..ortho..nd surgery cases to pvt hospitals..bypassing village RMPs. With monthly meetings where commission notes are exchanged, they have unfortunately developed into a formidable force no one dares go against. I think it is a very brave and commendable step to try nd tighten d noose around their necks."
>
> "Yes..dear lady docs Unfortunately..some of our fellow gynecs hav spoilt these Ashas with 50 pc commission. They solicit them with parties n gifts. Ashas come to us and give example of how out of 700 in scan..they get 300 nd how in delivery it is neat 50 percent. Then wat is use of all these MC and MD degrees. We shud identify such erring docs nd gently motivate them to stop d practice."

Sakshi aunty has also sent me two photos of local newspaper coverage of this standoff. One newspaper, *Sarhad Kesari*, summarizes the allegations from each side: "Many ASHAs have become *dalals* (brokers/pimps) instead of mediators, says civil surgeon. In response to the questions we raised about hospital services the civil surgeon started abusing us, say ASHAs." Another, *Bhaskar News*, reports that the protesting ASHAs have refused to return to work until the civil surgeon apologizes. "Hot burning issue.. Your Ashas are in trouble dear," writes Sakshi aunty.

Meanwhile, a WhatsApp group of ASHAs I am in is exploding with messages between the ASHAs of Muktsar and Fazilka. News reports, videos, audio clips, photos, and texts are flying. One of the first audios is from the Fazilka ASHA union, presenting their version of events. According to this audio, it all began with the gynecological staff on duty at Fazilka's civil hospital. Apparently, it had been a couple of days since an ASHA had checked in a pregnant woman for delivery, but the woman was not being attended to by hospital staff. Frustrated, the ASHAs registered a complaint with a helpline. This matter escalated to the civil surgeon, who, the audio alleges, used foul language in telling off the ASHAs. The civil surgeon accused ASHAs of squeezing their patients for commissions and *badhai*.[2] The speaker pauses to say, "we are not

[2] Cash given as gift/tip, in celebration, usually when a son is born

saying no ASHA takes commission. There may be one or two among us who let their greed get the better of them, but you cannot say all ASHAs are one hundred percent wrong. This blemishes our reputation." She suggests that the civil surgeon could have summoned the ASHAs, he received complaints against, to his office and issued them a warning in private. She laments the news coverage of these events as one-sided.

Then, as if to show the other side, she launches into a description of all that ASHAs do, day and night, no matter the patient or the ailment – tuberculosis, malaria, dengue, drugs. She emphasizes how dedicatedly they work and how poorly they are paid. "Again," she pauses, "I am not saying families don't give us *badhai*. They do. But only the families that can afford it. On their own, out of the happiness of their hearts, when there is a son they give us a hundred or two hundred rupees. To suggest we force patients to give us thousands is a baseless charge!"

Having dismissed the key allegations against ASHAs, she proceeds to make some allegations of her own. "Ten years ago," she thunders, "when there were no ASHAs, these hospitals were empty. Only postmortem cases. No deliveries. No other treatment. Now because of us, they have crowds, they have budgets. This is the real reason they dislike us, because they must work, they can no longer sit idle! From the staff to the doctor, they all take money from patients but the blame falls only on ASHAs!" She ends by imploring her ASHA sisters to join in the fight for their honor.

The exchanges that follow are too many to list here. Suffice to say, the texts primarily echo condemnation for the 'insult' levied by the civil surgeon, and plan actions against him. The Muktsar ASHA union, for instance, buses a group of ASHAs from Muktsar to Fazilka to join in the demonstration. Several photos are posted of small groups of ASHAs, usually union leaders, meeting with senior medical and district officials; they pose for the camera as they hand over a

memorandum of demands. More media coverage is shared. It is the media reports that prompt the most reactions. There is much outrage when a local doctor, part of the Indian Medical Association that rallied behind the civil surgeon, describes ASHAs as a "female gang," while another newspaper terms the grip of ASHAs on Punjabi society a bloodthirsty "*gunda raj*," literally, the rule of goons. Following this, a couple of ASHA union leaders share audio recordings of phone conversations in which they confront local journalists over this choice of words. Their main grievance: "this is a slur on our womanhood. How can you drag all our names through the mud like this? Aren't we daughters of Punjab?"

By early October, the issue fizzles out on the WhatsApp group. The still numerous messages become about routine matters.

My point in narrating this episode is not to uncover what really happened in the Fazilka civil hospital on the day the standoff began. Neither is it to track how the standoff would "resolve" itself. Rather, I use this event as an entry way, to demonstrate just how *susceptible* and *sensitive* ASHAs are to being labelled commission-hungry brokers. Reducing ASHAs, and only ASHAs, to commission-hungry brokers who divert patient traffic to the private sector is a narrow and misleading view of an entire ecology of health services within which ASHAs work. It is also sexist and classist because it brands any money-making on the part of working-class women as necessarily predatory. In this chapter, I take a broader view of the matter by highlighting a public-private sector dynamic in health services, that is *systemic* and that ASHAs both benefit from and are trapped by.

I first became aware of ASHAs' private sector links during my preliminary fieldwork in the summer of 2018. During a focus group discussion in the Fatehgarh Sahib district of Punjab, an urban ASHA, Teji, asked me what I realized later was a rhetorical question: "why is it that NGOs

pay ASHAs more for bringing tuberculosis patients to them than the government does?" Teji was my point of contact for this group. She had organized this meeting. She knew I was a clueless outsider with only questions and no answers. At the time I remember thinking, is she asking *me*?! Now I think she was *telling* me. Maybe she felt responsible for me coming away with a fuller picture. Teji wanted me to know that the knowledge and networks ASHAs so assiduously cultivate, are a goldmine for everyone else, including perhaps for the NGO that I had contacted her through.

Once I was onto this, I caught snippets of it everywhere. That same summer, Sakshi aunty was in Delhi on a shopping trip. We were chatting about my fieldwork that was coming up in a year and she said to me confidently, "Come to Muktsar, ASHAs bring patients to our hospital every day, I will line them up for you to talk to!"

When I finally got to Muktsar it was a different story. In the early weeks of my fieldwork, I was introduced to several ASHAs, but I didn't feel like I was breaking any ice. I stuck out like a sore thumb, and everyone seemed to maintain a respectful distance. I was dogged by the sense that I wasn't getting close to any action. What was this action? I couldn't say, but only because I hadn't seen it yet.

To break out of this tautological trap that was fast becoming an existential one (why am I here, what am I doing with my life), I got in touch with a PRO for a private hospital in the neighboring district of Abohar. A PRO is a Public Relations Officer. Private hospitals appoint PROs to bring in business. Their job essentially is to find and persuade persons of interest, persons who are in a position to refer patients to the hospital, with offers of commission. For instance, a PRO might offer you 20% of what the patient pays for every surgery you send his way. ASHAs are among the persons of interest PROs usually approach.

The PRO I spoke to was sympathetic to me. But he said in no uncertain terms: "Of course

ASHAs bring in cases but none of them will talk to you about that! They aren't supposed to do it, and they don't want any trouble."

Once he put it that way, it made complete sense. I felt foolish. This re-routing of patients for money could amount to corruption. Why would anyone show me that side to them? I was convinced I wouldn't gather enough data to understand what was going on.

I needn't have worried.

That ASHAs are treated as "ins" to the areas they service is hiding in plain sight. Given their reach in their communities, ASHAs are akin to gatekeepers of captive markets. Private providers come up with lures for ASHAs that can pave the way to these markets.

On a hot September day, still early in my fieldwork, I am sitting in on an ASHA training in the urban block. The afternoon session is interrupted when a member of the office staff enters to make an announcement. He requests the ASHAs to step into the courtyard, and hear out a "guest." Turns out the guest is a salesman for a local manufacturer of sanitary napkins. Like a TV advertisement, the salesman does a demonstration on a table that we all crowd around, comparing his company's pad with a pad from Stayfree. He pours water on the pads, tears them up, passes them around, commenting all the while on the superior quality of his *swadeshi*[3] pad. He wraps up by telling the ASHAs they can have the pads at a discount on the market price. He promises them more discounts for the more pads they distribute.

About half the ASHAs head back into the meeting room without taking the bait, while the other half buy a small packet or two each. I am still standing there scribbling into my notebook when the staff member who brought in this "guest" comes up to me and explains: "Please don't get the wrong impression, we don't usually promote any private company in our trainings, we are

[3] Literally, of one's own country. Here, Indian-made.

sarkari (governmental) after all it wouldn't be right, actually this is someone known to us, and he is promoting made-in-India so we thought it is a good thing…" I nod vigorously, to show I accept this explanation.

When the training wraps up, I accompany Indresh, a newly appointed rural ASHA, to the civil hospital where she wants to check in on a pregnant woman from her village. On our way there, our rickshaw passes a group of ASHAs from the training. They are getting off rickshaws that they have squeezed into, 3-4 women to 1 rickshaw. They look like they are assembling. They wave at us. We wave back. I ask Indresh, "where are they going?" She says, "Dr. Anju Gupta has called a meeting, I didn't go because of my patient." I am confused. Dr. Anju Gupta is the District Family Planning Officer. Her office is in the civil surgeon's office complex, where we just concluded the day's training. "They are meeting at her house?" I ask surprised. Indresh explains, "her house is also a hospital, Aashirwad hospital. Her husband runs it." I ask, "what is this meeting about," still confused about why Dr. Anju would call ASHAs to her home-cum-hospital after hours. Indresh, nonchalantly: "the usual, to discuss commissions, to tell ASHAs 'bring cases here'. That's what it always is."

The penny drops. Dr. Anju Gupta – a high ranking government official at the district level, a super-boss for ASHAs on many of the 'family planning' tasks assigned to them – routinely asks the ASHAs under her to bring patients to her husband's private hospital. A 'public-private partnership', you might say.

Dr. Anju's arrangement, however, is far from unique. I have been told by various people that government doctors often redirect patients they encounter on the job to private clinics run by the same doctors or their families. Staff at government hospitals too might redirect patients to private clinics for commission. ASHAs, then, are only the latest participants in a long tradition of

private sector capture of the state's health system. I say capture because patients are rendered hostage by this practice. Poor and vulnerable patients, not in a position to disagree with their doctors, can end up paying amounts high enough to put them in debt, for care that may or may not be safe or adequate.

The next day at the training, I am sitting next to Indresh. During tea break, Indresh asks the ASHA sitting in front of her about yesterday's meeting at Dr. Anju's. The ASHA tells her Dr. Anju has asked them to bring more patients for scans to her hospital; the patient is charged Rs.. 600 (USD 8.5), of which Rs. 200 (USD 2.8) will be the ASHA's commission. Because Indresh is new, she asks about scan charges at other hospitals. They discuss one hospital that charges Rs. 650 (USD 9.2), and another that charges Rs. 550 (USD 7.8). Indresh makes a note of the place that charges Rs. 550 in her diary, muttering almost inaudibly "my patients are poor, so the cheaper the better for them."

I was privy to several conversations of this type, where private hospitals were discussed. It appeared that in accessing the private sector, ASHAs attempt to strike a balance between what their patient can afford, and what is on offer from hospitals, public and private. Take Indresh's example. At the time that she is zeroing in on a private scan center, the government hospital does not have a radiologist on staff and so cannot offer ultrasounds for all the patients who come in. As a result, ASHAs must take the pregnant women under their care to a private scan center. Indresh, who gets a standard commission across scan centers, settles on the one that is the cheapest for her patient.

On one occasion, I am sitting with 3-4 other ASHAs, digging into *samosas*. Guneet, a rural ASHA, joins in late. She explains where she is coming from. She was with a hysterectomy patient, a relative of Amarjot sir's. Amarjot sir is one of the trainers, so all the ASHAs know him. "The

hospital was going to charge 26000 and I brought them down to 20000," she says. Everyone nods. They concur with Guneet when she says, turning to me, "He is nice. His village is by mine, that's why he asks me." This spurs some conversation about private hospitals – "Dhariwal hospital is totally useless," complains Gagandeep, an urban ASHA. Dhariwal is a private children's hospital. The civil hospital does not have a neo-natal ICU, so children who are sick must go to a private hospital. Gagandeep explains that Dhariwal hospital is bad for patients because they hang on to the serious cases they cannot treat, for too long. By the time the patient is referred elsewhere it is very late. "Don't send serious cases there," advise the others, "only non-serious cases."

ASHAs navigate a dense and dynamic ecology of public, *and* private hospitals. These hospitals hanker after ASHAs, pursuing them through PROs, with competing offers of commission at 'parties' where they serve snacks and make their sales pitch, as well as with gifts on Diwali. There is no doubt that ASHAs partake of what private hospitals offer. However, that ASHAs participate in this ecology and routinely refer patients to private hospitals, earning commissions for themselves, is not a grand indictment. In doing this, ASHAs also take their patients' interests into account because they must. After all, ASHAs' relationships with their patients *are* their primary capital. These relationships are built over time and take trust to sustain. Because most ASHAs live in the communities they serve, their proximity to patients produces an organic accountability—they are sensitive to what their patients think of them. Losing patients, because of poor quality and overpriced care for instance, is a damaging proposition. For ASHAs, losing patients means both losing money and, through the loss of reputation, the means to make money. This explains Gagandeep's disdain for Dhariwal hospital.

In my interview questionnaire, I include several questions about the private sector. I ask ASHAs if they know private hospitals well, which private hospitals they frequent and why, and if

they prefer private or government hospitals. Many ASHAs denied going to private hospitals. But many also readily admitted that they took patients there. They would explain that they took only those patients who did not want to deal with the conditions at the government hospital and who could afford to pay for a private provider. “The trade-off is between time and money,” one explains to me, “private hospitals take money, public hospitals take time.” ASHAs pick among the many private providers based on several variables, one of which is the ASHA’s familiarity with the provider. Dr. Anju Gupta’s hospital was among their top private picks. Also frequently named was Dr. Seema Gulati. Muktsar’s ASHAs knew Dr. Seema well from her time as a gynecologist at the civil hospital. I was told that even before Dr. Seema quit the public sector and began to focus solely on private practice, she would tell ASHAs coming into the gynae ward of the civil hospital to bring patients to her private practice as well.

In her interview, Lakhvir, rural ASHA since 2008, sheds light on how ASHAs navigate the private sector.

> Me: Do you know private hospitals well?
>
> L: I only go to the private hospitals I know well. There are so many private hospitals. I don’t go to the ones that don’t treat you well.
>
> Me: So where do you go?
>
> L: I used to take a lot of cases to Ginni. Near the gurudwara, you know? (I nod) I have been to Dilli hospital too, but they wouldn’t give any incentive. Even if I spent three nights with a patient there, they would say to me, this is an old patient who has been coming here from before your time. I don’t like how they behave there. Then Kalpana on Bathinda road, she is on the expensive side… So why take poor people there. The thing with Ginni is, if I take SC patients there, and I tell her madam they can’t pay so much, then instead of 9000, she will charge 4000. She will bring 7000 down to 5000.
>
> Me: But then what is left for you?
>
> L: She always gives incentive! Even if she charges 7000, she gives 3000 to me. So I prefer Ginni.

When I ask Lakhvir if she prefers working with private or government hospitals, she is categorical that she prefers government hospitals. She says: “I want more and more people to use government hospitals. That is our identity. The more I work with *sarkari,* the better my record will be. See, money comes and goes. I can’t keep money with me forever. Bringing people to *sarkari*, now that takes dedication. And it earns you a lot of respect. It matters a lot to people in the village that their treatment was free. It matters that they saved 10,000 that they would have spent had they gone to a private hospital.”

Lakhvir understands the importance of goodwill. She has just contested elections for local office. She tells me that even though she lost, she is proud of the votes she got. Like Lakhvir, many ASHAs I spent time with were honest about their earnings from the private sector. One afternoon, I am on a bus ride with a group of ASHAs. We are returning from a protest in another city. Kuljeet, an urban ASHA with a winning smile, is in a particularly good mood. She tells me she earned well last month, and has decided to buy a pair of earrings for herself. She shows me a picture on her phone. The earrings are little gold balls hanging off a short, single chain. “I like simple designs,” she declares. I ask her how much she made, half expecting her not to answer. “10,000 (USD 142)” she says, widening her eyes. “3500 (USD 50) from the ASHA work, 4500 (USD 64) from 3 tuberculosis payments that finally came through and the rest from private. I never tell my husband how much I make from private. I spend it on myself. In the future, it will all go to my daughters.” Another ASHA joins in the conversation. This is Navdeep. I ask her, is it about the same for you? She tells me it is usually half and half. “I make about 3-4000 a month from the ASHA work, and another 3-4000 from private cases.”

In time, I see first-hand how private hospitals recruit ASHAs. I am present for a ‘Diwali party’ that a new children’s hospital, Capital hospital, hosts for ASHAs.

On the day, we gather in a big, carpeted room in Muktsar's main gurudwara complex. Two male PROs repeatedly announce that all ASHAs should enter their names and numbers in the register that is being passed around. The room is packed, but more women are streaming in. It is hard to hear over the chatter. Two ASHA union leaders rise to make a couple of announcements. One of them, Preeti, begins by saying, "it is shameful how many of us have gathered to collect a gift, but the union struggles to get a decent turnout when we call a meeting." She then begins her speech, going over recent developments that showcase the union's efforts. Her speech is interrupted by a call on her mobile, which she steps out to receive. She returns grinning. She announces, "if you have any de-addiction patients please bring them to Rabrakha." (At this time Preeti is also a PRO for a private de-addiction clinic called Rabrakha) "The ASHA will get Rs. 100 (USD 1.4) for every patient card she gets made." She cracks up, "we can all get cards made for ourselves!"

There is more chatter after Preeti is done. Then the two men address the room. They begin by apologizing that the doctor couldn't make it. They explain the facilities at their hospital, saying it is certified as the most advanced children's hospital in the area. They will give 25% commission. An ASHA speaks up from the room, "but you are expensive, patients don't want to go to your hospital…" The PROs respond: "if you take the child to another hospital, they will end up referring the case to us as well but only later. If you bring the child to us directly, then the longer the child is with us, the more the bill, and the more your commission."

Another ASHA asks: "Do you provide transport?"

PRO: "Yes we do, we have two vehicles. When you have a delivery case just call me, I will send the vehicle to civil."

Preeti: “How can we know before the child is born that there will be a problem? We can only call you after the delivery and your vehicle should come ASAP.”

PRO: “Yes, totally.”

Preeti: “It shouldn’t be like what happened to me the other day. I had been handling this patient for nine months. She got referred from civil but didn’t want to go all the way to Faridkot. The family decided to go to Dr. Anju’s. This should have been my case. But they gave the commission to the driver who took them there.”

Another ASHA from the back of the room stands up, and narrates a similar story where she was denied commission that she says was due to her. The PRO intervenes: “look, if the gynecologist refers the case, it will be her commission. If the ASHA refers the case, then it will be the ASHA’s commission.” This does not resolve the matter. Several ASHAs pipe up: “But it is the ASHA who takes the case to the gynecologist!” This goes on for a little while longer, till the PRO assures them his hospital will work it out, probably by splitting the commission.

Small paper plates with *samosas* are handed down the rows where we are seated. This is the end of the meeting. I step outside to get *chai*. A PRO from another hospital is standing by his motorbike, handing out visiting cards. Everyone is milling about. The ASHAs are holding cardboard boxes. This is the Diwali gift from Capital hospital: a set of six ceramic teacups.

The Diwali party shows me just how aggressively ASHAs are courted by private hospitals. More importantly though, it shows me that ASHAs are not docile dupes who fall for any and every offer made by a private hospital. ASHAs are aware that their position as mediators is a valuable one. This is a form of power for them, and they try to wield this power with private hospitals. They ask questions of the Capital hospital PROs. They make demands. With the de-addiction center Rabrakha, Preeti even suggests that they game the system, securing the Rs. 100 commission by

getting cards made under each other's names. Preeti is joking. But her playfulness indicates how routinized offers from private hospitals are for ASHAs, and how adept ASHAs have become at sorting through them.

If I needed any more evidence of how valuable ASHAs are for the private sector, I have it when I get home that day. Sakshi aunty asks me how my day was. When she hears about the Diwali party by Capital hospital, she is buoyed. She tells me she too wants to throw a party for ASHAs. She asks me to mobilize all the ASHAs I know in Muktsar for this party. It takes me several conversations with my advisor, Sharmila Rudrappa, over several days, to figure out how to dodge this one. In the end I shoot from Sharmila's shoulder, saying my advisor won't allow it. That working with a third party creates conflict for my research.

The question however remains: just how serious of a problem is ASHAs' private sector ties? I ask Sukhdev, the district community mobilization officer, when I interview him. Sukhdev oversees the ASHA program for Muktsar district, and of all the officials in my field is perhaps the most familiar with how ASHAs work.

> Me: In your assessment, to what extent are ASHAs taking patients to the private sector? And how harmful or harmless would you say this is?
>
> S: Look, there are two issues here. We are making ASHAs work on incentive. When someone is your employee and you give a fixed salary, then you have rights over them. You can warn them. 'Don't you dare go to private hospitals, we do not allow it and we will dismiss you if you do.' Right? Now I agree that there is an arrangement going on. ASHAs have become a part of the health department. They have earned a name for themselves. People trust ASHAs now. ASHAs have ties with private hospitals. Yes, they know all this now. But do ASHAs coerce patients into making payments that are illegitimate? That percentage is very low. Mostly, ASHAs feel that if a patient wants to use a private hospital and can afford to, then why not take that patient to private. I have seen this. When something is outside their purview, not a delivery case for example but a Bhagat Puran case,[4] they will take that patient to private. PROs do so much publicity right. Everyone is taking commissions. In my experience, for patients who are poor and cannot afford to pay,

[4] A publicly funded health insurance scheme for the poor, where the government pays private hospitals to service poor patients.

> ASHAs bring them to the government hospital. But patients who can afford it, who want to go to private, ASHAs take them to private hospitals.
>
> Me: So you don't think this is a big problem or anything?
>
> S: Problem… It is a problem when they take unnecessary cases. Look, if it were up to us, as members of the health department, we would want everyone to use government services. When the government is making so much infrastructure and staff and everything available, then ASHAs should motivate everyone to use these services. They should even motivate those who can afford to go elsewhere. Our gynecologist has a salary of 40-50,000 a month, and has all the set-up she needs, but if she does only 4 deliveries then that means each delivery is costing the government 10,000! So why shouldn't we do more deliveries here? For the ones who can afford to pay, I think ASHAs let it slide. They are happy to go along. They think, 'it's okay, let this patient use private, it will earn me something more too.' Now if I think from my level, this is a problem. If I think from the ASHA's level, it is fine. She does so much. At least whoever needs healthcare is getting it.

Sukhdev acknowledges that ASHAs receive commissions from private hospitals. He surmises that a majority of these cases are legitimate in that the patient is willing and able to pay. Therefore, he does not see this practice as hurting individuals. In fact, he hints that this might be a reward for ASHAs who work so hard but get only incentives in return.

However, as a public health official, Sukhdev emphasizes a more abstract harm—the cost to the public sector. He frames this in terms that are both utilitarian (the greatest good of the greatest number is only possible through the government sector) and monetary (the government is being robbed of the biggest bang for their buck).

The untrammeled growth of the private sector and the hollowing out of the public sector is not a victimless crime. As the lowest in the pecking order, ASHAs cannot be expected to swim against the tide of health care provision. However, the cost of a public health system that is deeply entangled with private profiteering from health is not abstract even though it might present itself as such. This cost is borne by individual patients as unnecessary medical procedures, risk of morbidity and mortality, and out-of-pocket expenditures. It is also borne by the collective as the erosion of their right to health. And finally, it is also borne, in one way, by ASHAs who can get

caught in the crosshairs of public hospitals, private health providers, and the private lives of public providers.

Sheenu calls me one night in November because she is too anxious to sleep. One of Sheenu's patients, Rina, has tuberculosis and was pregnant with her third child. Rina's first two deliveries were C-sections. During the second pregnancy, Sheenu had taken Rina to the civil hospital for delivery. But the hospital staff did not want to take on a tuberculosis patient, so they referred Rina to Faridkot, the neighboring district with a bigger civil hospital. Back then, Rina did not want to make the trip to Faridkot. Rina decided to go to a private hospital instead. Sheenu, concerned about Rina's family's finances, intervened. Rina's husband had pawned his motorcycle to be able to pay for the birth of their second child. Sheenu knew this, so she used her influence with Dr. Seema Gulati to get Rina a discount on the C-section- Rs. 14,000 instead of the usual 20,000.

Now with this third pregnancy, Sheenu has been making regular visits to Rina's house. Rina's previous experience with the civil hospital has left a bad taste in her mouth. But Sheenu persuades her to give the place another shot.

Rina begins experiencing labor pains at 1.30 AM on the 18th of November. At 5 AM, Rina's family contacts Sheenu, and soon after Rina is admitted to the civil hospital for delivery. But the staff at the antenatal ward reacts to Rina "like she is a ticking bomb," and directs Sheenu to take her to the tuberculosis ward instead, located on the first floor. There, the ward attendant gives Rina an injection, but her pains continue. Sheenu tells her to be patient, and comes away briefly. But Rina is in unbearable pain. She comes down to the antenatal ward looking for help, where a nurse gives her some pills and sends her back up the stairs.

By this time, Rina is fed up. She does not want to keep going up and down the stairs in her

condition, and is convinced the baby is on its way even though everyone is telling her there is time (later Rina would say that the baby's head was practically out). At this point, Sheenu is away for a cup of tea. Rina and her family leave the civil hospital, unwilling to wait. They go to a *dai* (midwife) in their neighborhood, known as 'Bindu nurse.'

As soon as Sheenu finds out about this, she and her ANM Preet rush to Bindu nurse's home. They get there just as Bindu nurse is delivering Rina's baby, a boy. It is a vaginal birth. "She was so calm and deft." Sheenu recalls. ANM Preet steps out to make a phone call. She is required to report all home births to the District Family Planning Officer, Dr. Anju Gupta.

Meanwhile, Rina's family is cross with Sheenu. After all, it was Sheenu who had insisted that they go to the civil hospital. Sheenu had told them the delivery would probably be a C-section. Once in the hospital, Sheenu had said it wasn't time yet for the baby to be out. Rina's mother says to Sheenu in a fit of anger, "I will tell everyone on our street not to go to the civil hospital, because no one gives a damn about you there!" Bindu nurse steps in to respond. She assuages the family and comes to Sheenu's defense: "It is not her fault. Her job is to take you to civil. She is not responsible for what happens there. She has been taking care of you for so many months. You should be giving her *badhai*!" The family then put a box of sweets and a Rs. 500 note in Sheenu's handbag.

A few hours later, Dr. Anju Gupta visits both Rina's and Bindu nurse's homes with a "team" to conduct an "inquiry" into the home birth. Sheenu is not present for the visits. She is upset when she finds out about them. During the visit, Dr. Anju outs Sheenu's ANM as the one who "complained," even though this should have been kept confidential. Dr. Anju also asks many questions about the ASHA on the case: "Did she accompany you? Did she take money from you?" Sheenu will have to appear before her soon. This is making her restless, anxious, unable to sleep.

She says repeatedly on our phone call, “no good deed goes unpunished.” Her biggest concern is *badnaami*, getting a bad name.

This incident is discussed among several ASHAs I hang out with over the next few days. I hear many takes on it, but have no way of sifting fact from fiction. Someone says there is a nexus between Bindu nurse and Dr. Anju; Bindu nurse can do home deliveries as long as they are normal/vaginal, and she refers all C-section cases to Dr. Anju’s hospital. “Of course she has Dr. Anju’s blessing, why else is she being allowed to practice from home,” this ASHA insists. Someone else claims Bindu nurse’s husband paid a visit to Rina’s family: he has taken their thumb impressions (they are illiterate so cannot sign) on empty sheets of paper, as a sort of insurance. She speculates that he will write a statement against Dr. Anju on behalf of Rina’s family should Dr. Anju take any action against Bindu nurse. Sheenu thinks Dr. Anju is out to get her because Sheenu uses Dr. Seema Gulati’s hospital for her private cases and not Dr. Anju’s. Sheenu has worked it all out. Dr. Anju is going to have her kicked out for taking *badhai* from Rina’s family. Or maybe for leaving their side to take a tea break. Sheenu can’t be sure. But she is convinced something bad will happen. She has a heavy, ominous feeling that she can’t shake off.

When Sheenu finally meets Dr. Anju, it is anticlimactic. Dr. Anju asks her some questions, and tells her to turn in a written statement. Right before she lets Sheenu go, Dr. Anju says casually, “you should bring cases to my hospital.” When I meet Sheenu afterwards, she looks relieved. In a voice dripping with sarcasm she declares, “Dr. Anju zindabad! (Long live Dr. Anju)”

Conclusion

Bureaucracies have been understood as impersonal entities, with uniform rules aimed at achieving uniform outcomes for everyone, regardless of their social standing. My work follows street-level bureaucrats and the intimate, affective relations they build on account of their gender, class, and caste identities. ASHAs are marginalized women who form connections with other marginalized women, to connect them to health services. As mediators between social systems, ASHAs craft themselves into highly sought-after actors. They labor to create intimate ties with other women in their communities. By enabling access to services and educating their communities in the culture of the state, they become a resource for their communities. In turn, their communities become a resource for them, giving ASHAs the social capital to earn money, respect, and political clout.

ASHAs work to better reproductive health outcomes. But through their work ASHAs help reproduce not just citizens, but the state itself. By expanding the welfare arm of the state, ASHAs reproduce state legitimacy. But simultaneously, they also help reproduce the prevailing ecology of health delivery in which the public and private sectors are entangled.

I explore how the state is instantiated, or made real/meaningful, both *for* street-level bureaucrats and *by* them. Why and how do ASHAs see the Indian state as worthy of attachment? Bourdieu writes on the idea of the state's symbolic capital (Bourdieu et al. 1994). To Weber's definition of the state as the legitimate holder and implementer of violence, Bourdieu adds that the state holds "monopoly over symbolic violence." According to Bourdieu, the state exerts symbolic violence because it incarnates itself objectively (organizational structure) as well as subjectively (mental structure or categories of thought). To denaturalize the state, Bourdieu offers a model of

its emergence: the state is a culmination of a process of concentration of different species of capital. The ability to grant power over these different capitals makes the state the holder of a meta-capital, called statist capital, which holders with different capitals struggle for. The different capitals are physical force, economic capital, cultural or informational capital, and symbolic capital. For Bourdieu, symbolic capital—the power to authorize—is a genuinely creative and quasi-divine power of the state. It can manifest as juridical capital, or as honors attributed by the state. Like any fiduciary currency, these have value in all markets controlled by the state.

I derive what I call "promissory capital" to explain the material but especially the affective pull of the state. I define promissory capital as the ability to make a promise. This promise necessarily projects on to the future, but it does not fully ignore the present. It sustains itself in piecemeal ways in the present, in the process fueling its charge for the future. Promissory capital indexes a mechanism through which legitimacy is secured for the state's workers. For ASHAs the state's promise is of salaried, tenured employment. This promise works not despite the shrunken-ness of the state, but because of it. By shrunken I mean a state that is shedding its responsibilities to labor, as the Indian state has done since the 1980s. In embracing neoliberal policies, India has de-regulated industry and informalized labor by rolling back labor protections (Agarwala 2008). Since the 1980s, the Indian state has changed its industrial policies dramatically, decreasing bureaucratic controls, increasing privatization, and opening up the economy to international flows. This has had an enormous impact on labor. The Indian state has been encouraging informal employment—low cost, flexible, and unprotected labor—which now makes up 93% of the national labor force (Agarwala 2008). This also extends to employment within the state. In what feminist economist Padmini Swaminathan (2015) calls the "formal creation of informality," the Indian state has informally employed mostly women to deliver services in the formal health and education

sectors. ASHAs are an example of such a workforce. But they are not the only example. This informalization also extends to the state's own labor force, especially in health and education services, such as ASHAs (Swaminathan 2015).

If we accept that the state is primarily an ideological artefact, one that attributes unity, morality, and independence to the disunited, amoral, and dependent workings of government (Abrams 2008), then promissory capital is a "state idea," an image constituted as reality. The state's uniquely creative ability to make a promise produces an effect: here, legitimacy for its workers. It is in the ordinary and banal experiences ASHAs have with state agents and state policies that the conditions for the continuous affirmation of state legitimacy are met, that the pull of the state on their consciousness is justified. This pull does the work of keeping ASHAs in place. It does so by both deferring their big ask—the *sarkari naukri*—and managing this deferral in piecemeal ways.

By bringing marginalized communities into the fold of welfare programs, ASHAs perform the important if mundane work of political socialization. Welfare programs bolster the legitimacy of the state. The everyday reproduction of the state is aided by, even if not wholly dependent on, this kind of state formation "from below" (Steinmetz 1999). Welfare is at the center of the expansion of citizenship in postcolonial India. Informal sector workers, for instance, use the rhetoric of citizenship rights to make welfare claims of the Indian state, rather than demanding benefits from employers (Agarwala 2008). Through their work for the state, ASHAs *actualize* claims, enabling people to realize social rights already granted, thus deepening their lived experience of citizenship. This in turn aids the expansion of ASHAs' political rights. Here I build on both, T.H. Marshall's (1950) classic formulation of citizenship as civic, political, and social rights, as well as feminist critiques of Marshall's formulation that insist the evolution of rights is

neither linear nor automatic.

I also build on literature that maps bureaucratic encounters onto social structure. My findings emphasize the role of caste in interactions between ASHAs and their clients, as well as the reliance of marginalized communities on the state. As a corollary then, the erosion of state services is the erosion of the public good with the largest effect on marginalized communities. As India's development model prioritizes public-private partnerships, it is imperative to recognize the caste of our commons. I join other scholars who point out that despite being one of the most important determinants of life opportunity in India, caste does not receive the same kind of attention as gender and race, and is largely absent from discussions of development (Mosse 2018).

ASHA represent a social capital story in the context of paid care work. Forming emotional bonds with care recipients has long been recognized as a component of care work. However, the tendency is either to romanticize these bonds—suggesting that closeness and altruism is its own reward and makes up for low pay—or to categorize affective ties as concealing the exploitative nature of the work[1] (Hondagneu-Sotelo 2007). My findings show that under certain circumstances, women activate emotional bonds with care recipients as social ties. This demonstrates that low wage healthcare jobs are not necessarily dead-end, non-creative, and primarily exploitative for the women in them as depicted in literature focused on working class minority women in the West (Chang 2000; Glenn 1992; Hondagneu-Sotelo 2007; Parreñas 2001). Expanding our field of research to include non-Western contexts can sharpen our theorizations of care to bring them closer to diverse empirical realities, even offering important correctives.

These findings challenge the "love versus money" framework in which discussions of care work are often stuck. This framework, used by neo-classical economists, suggests that women

[1] The rhetoric of 'family bond' in domestic care work, for instance, masks the inequality of the care work arrangement (Hondagneu-Sotelo 2001).

perform unpaid care or participate in paid care work for "love" (intrinsic rewards) and that these make up for the lack of "money" (extrinsic rewards). (Zelizer 2002) calls this the "hostile worlds" approach, that is, the tendency to assume that love and money are mutually exclusive motivations for care. This assumption leads people to conclude that paying for care undermines love and, by extension, quality of care. However, the love versus money binary "conceals enormous variation in the forms that intrinsic and extrinsic motivations can take, as well as the ways in which these forms can be combined" (England, Folbre, and Leana 2012: 21). In real-world situations, intrinsic and extrinsic rewards in care can and do complement each other. To imagine otherwise, to conjure an image of a selfless care worker, is to disregard how demoralizing a lack of extrinsic rewards can be (Folbre and Wright 2012). For instance, research suggests that extrinsic rewards that are seen as acknowledging/ conferring recognition can "crowd in" intrinsic and prosocial motivation (Ibid). Research also suggests that people performing care work can develop more caring preferences, for instance, workers can acquire sentiments for clients (England et al. 2012). We also know that the lack of extrinsic rewards can "crowd out" intrinsic motivations. This is why there is high turnover amongst frontline health workers even though they report enjoying the job (Morgan, Dill, and Kalleberg 2013). In sum, research on motivation to provide care "does not support a simplistic model in which money crowds out prosocial motivation; nor does it suggest that care provided out of love is always superior to care provided at least in part for pay" (England et al. 2012: 37). In fact, the notion that care should be provided for love rather than money can serve to legitimize gender inequality and justify poor working conditions, low pay, and lack of career advancement.

I respond to the call that "a first step in challenging the conventional polarity between love and money lies in describing combinations of intrinsic and extrinsic motivation" (Folbre and

Wright 2012:17). With ASHAs, not only do I find no dichotomy between love and money, I find an integration of intrinsic and extrinsic rewards with the latter driving the former. ASHAs value money as (extrinsic) reward, and experience other (intrinsic) rewards that are borne of their position as income earners.

I join the call for policymakers to find equitable and efficient ways to combine love and money in care (England et al. 2012: 37). Ramirez-Valles (1998) finds that much of the Community Health Worker (CHW) literature identifies low education and poverty as positive features that create identification of the community with the health worker. This also shapes the notion that in order to be close to the community, CHWs should not be paid a salary or should be paid only by the community. This fits well with another construction in CHW literature- of women as nurturers, who can speak easily to other women, and who have the free time and natural altruistic inclination to work without pay. Without empirical examination, these ideas circulate as justifications for poor working conditions, particularly low levels of pay, for CHWs.

Scholars have long investigated the wage penalty in care, to show its disproportionate impact on women from marginalized race and class backgrounds, and to argue for improved measures of care to raise wages in care (Budig et al. 2019; Duffy et al. 2013; England et al. 2002). I draw attention to an understudied aspect of the wage for care: not how much is paid, but how the wage is structured, that is, as incentives rather than salaries. I demonstrate that incentivized pay is a defining feature of ASHAs' vulnerability because it creates conditions for chronic underpayment and control. This shows how the standard of both wages and working conditions in care is being lowered today.

The World Health Organization recommends that CHW programs be appropriately financed to ensure services are sustainable, and that CHWs receive adequate wages (Kasteng et al.

2016). A commensurable salary is the first step towards increasing the motivation of health workers (Chandler *et al*. 2009). Every ASHA in my study sought tenured, salaried employment from the government. At the very least, they wished to be paid more. I find that incentives are a narrow and problematic metric for payment. Metrics that do not accommodate "relationship-based, open-ended, unscripted care" (Baines & Armstrong, 2019, p. 940) actively render it invisible in documentary and workplace practices. By designing metrics that are narrowly target-focused, states "manufacture conditions for unpaid care" (Ibid).

With COVID-19, ASHAs have been at the forefront of monitoring, referring, and managing positive cases. If their expanding workload and the current public health environment are any indication, then the services that ASHAs and other frontline health workers provide will only grow in significance. The experiences of this workforce, therefore, matter for society's well-being as much as their own. The diversion of patient traffic from the public to the private sector, no matter how well-intentioned, can create poorer outcomes for patients. Caesarean births and neonatal mortality are higher in private hospitals compared to public hospitals (Coffey *et al* 2021). This difference is not explained by more complicated caseloads alone, and points to serious gaps in the quality of care in private hospitals (Ibid). Through ASHAs' ties to private hospitals, the ASHA program may well continue to be successful in the face of untrammeled private sector expansion. Certainly this is the direction in which India is headed. But this success would be akin to a self-goal for public health. At the minimum, one can conclude that the neo-liberal iteration of the community health worker model is not an answer to health system woes.

My findings underline the need to expand scholarship on the political potential of care work. I do not argue that all care work is political socialization of a public nature, although it can be argued that all care work nurtures human capacities that bolster all human activity, public and

private. However, in certain situations, care work has direct impacts on the sustenance and growth of states, social movements, and civic life. Finally, as Sharma and Gupta (2006) note, while nationalism has been theorized in cultural and affective terms, states are mostly understood in institutional and functional terms. Here I make a case for more scholarship on the social life of states. The social life of states can help us trace the multiple meanings people attach to the state—particularly meanings that exceed cognitive framing, how these meanings map onto social structure, what negotiations they engender vis-à-vis the state, and the various effects these negotiations have on maintaining or challenging state power.

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